

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15761

CERTIFICATE OF DEATH

15764

| | | | | | | | | |
|--|--|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>—</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u> | | | | d. STREET ADDRESS <u>901 Arcola Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Abrams</u> Last <u>Abrams</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1966</u> | | | | |
| 5. SEX <u>Fe.</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/29/1900</u> | | |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> | | IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>BELLA SILVERMAN</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT <u>ALLAN ABRAMS -</u> | | | |
| | | | Address <u>1713-TIFTON DR NW</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>66</u> , to <u>Nov. 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> , 19 <u>66</u> , and that death occurred at <u>105A</u> A.M., from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <u>Raymond W. Turner</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/15/66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>RAYMOND W. TURNER</u> | | | | 22d. ADDRESS <u>2121 PENN AVE NW WASH DC</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>11/16/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>ARL. NATL. Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>ARL. VA.</u> | | |
| 24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> | | | | ADDRESS <u>4217 5th St. N.W.</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 17 1966</u> | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |

MEDICAL CERTIFICATION

Cleared with Medical Examiner (Omidpour)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED
JAN 10 1964
U.S. AIR FORCE
AIR MAIL
10000

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|---------------|--|----------------|--|
| TO: [] | | FROM: [] | |
| SUBJECT: [] | | REFERENCE: [] | |
| DATE: [] | | TIME: [] | |
| LOCATION: [] | | STATUS: [] | |
| REMARKS: [] | | ACTION: [] | |
| INITIALS: [] | | SIGNATURE: [] | |
| OFFICE: [] | | BRANCH: [] | |
| GRADE: [] | | SERIAL: [] | |
| ID: [] | | CODE: [] | |
| REMARKS: [] | | ACTION: [] | |
| INITIALS: [] | | SIGNATURE: [] | |
| OFFICE: [] | | BRANCH: [] | |
| GRADE: [] | | SERIAL: [] | |
| ID: [] | | CODE: [] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If the deceased was removed from the place of death, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MD MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15762

CERTIFICATE OF DEATH

15765

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | d. STREET ADDRESS <u>1615 Timberline Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Infant</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/21/66</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>4</u> yrs. |
| 13. FATHER'S NAME <u>Paul Ahmed</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A. Maryland</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 12. CITIZEN OF WHAT COUNTRY? |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth, neonatal death</u> DUE TO (b) <u>abruptio placenta</u> DUE TO (c) <u>7615</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4:30 PM 11/21/66</u> , to <u>8:30 PM 11/21/66</u> , that (I) (we) lost saw the deceased alive on <u>8:30 PM 11/21/66</u> , and that death occurred at <u>8:30 PM</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Herbert J. Jacobs</u> | | 22b. DATE SIGNED <u>11/21/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Herbert J. Jacobs, M.D.</u> | | 22d. ADDRESS <u>2401 Blueridge Ave., Wheaton, Md.</u> | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) | 23b. DATE THEREOF <u>11/22/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> | 23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> | | 25. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u> | |

RECORDED BY REGISTRAR

DATE NOV 23 1966

13705

DEPARTMENT OF HEALTH

13705

PROBATION DEPT., GENERAL DEPT.

PROBATION DEPT.

2nd 1st Division Ave., Chicago, Ill.

Herbert J. Jacobs, N.Y.

1st of Nov. 1910

1910

1st of Nov. 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15763

CERTIFICATE OF DEATH

15766

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. LENGTH OF STAY IN 1b <u>15.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4209 COLCHESTER DRIVE</u> | | d. STREET ADDRESS <u>4209 Colchester Drive</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Desmond Ajitkumar Ananthanayagam</u> | | 4. DATE OF DEATH <u>November 7 1966</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>COLORED</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEP 8, 1960</u> |
| 9. AGE (In years last birthday) <u>6</u> yrs. | | IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Ceylon</u> | |
| 13. FATHER'S NAME <u>Quintin Jebaarul Ananthanayagam</u> | | 14. MOTHER'S MAIDEN NAME <u>Daisy Elizabeth Velayuthan</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Address</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>Mongolism</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>SEP 8</u> , 19 <u>60</u> , to <u>Nov 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>OCT 18</u> , 19 <u>66</u> , and that death occurred at <u>9 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John A. Washington</u> | | 22b. DATE SIGNED <u>Nov 7 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>John A. Washington</u> | | 22d. ADDRESS <u>1901 Wyoming Ave., N. W. Washington, D. C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-10-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u> | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

12708

DEPARTMENT OF HEALTH

12708

NOV 1 1955

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15767

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b 15 1/2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. SAN. & Hosp | | d. STREET ADDRESS 8312 HADDON DRIVE | |
| 3. NAME OF DECEASED (Type or print) AXEL WILLIAM ANDERSON | | 4. DATE OF DEATH Month NOVEMBER Day 1 Year 1966 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 17, 1898 |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY CONNECTICUT | |
| 11. BIRTHPLACE (State or foreign country) CONNECTICUT | | 12. CITIZEN OF WHAT COUNTRY? AMER. | |
| 13. FATHER'S NAME EDWIN ANDERSON | | 14. MOTHER'S MAIDEN NAME CHARLOTTE MULMQUIST | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. MRS. GOLDA ANDERSON - SAME AS Pt. | |
| 17. INFORMANT MRS. GOLDA ANDERSON | | Address - SAME AS Pt. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Belden R. Reap | | 22. DATE SIGNED Nov. 2, 1966 | |
| EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. | | DEPUTY MEDICAL EXAMINER Nov. 2, 1966 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 5, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington D.C. | |
| 24. FUNERAL DIRECTOR James Walters, 254 Carroll Rd. N.W. DC | | 25. REC'D BY REGISTRAR Nov 4 1966 | |
| 26. REGISTRAR'S SIGNATURE Charles Judge | | | |

15763

15763

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

Medical Examiner Approved

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|----------------------------------|--|---|--|---|--|---|---|---|----------------------------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 15765 | | | | | 15768 | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY <u>Montgomery</u> MARYLAND | | | | | a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. LENGTH OF STAY IN 1b <u>7 years</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2312 Arcola Avenue</u> | | | | | d. STREET ADDRESS <u>2312 Arcola Ave</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Frank Thomas Anderson</u> | | | First Middle Last | | | 4. DATE OF DEATH <u>November 2 1966</u> | | | Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-27-99</u> | | 9. AGE (In years last birthday) <u>67 yrs.</u> | | 10. UNDER 1 YEAR Months Days Hours Min. | | 11. UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Transportation clerk</u> | | | | 10b. KIND OF BUSINESS OR PROFESSION <u>John Hopkins Hosp. Applied Physios</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Frank Thomas Anderson</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Eugenia Carter</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | 16. SOCIAL SECURITY NO. <u>577-28-6208</u> | | 17. INFORMANT <u>Mrs. Janet J. Anderson</u> | | | Address <u>2312 Arcola Ave. Silver Spring, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March, 1957</u> , to <u>Nov 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 28, 1966</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE <u>Edward J. Richards</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED <u>Nov 2, 1966</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards, M.D.</u> | | | | | 22d. ADDRESS <u>10110 Georgia Avenue Silver Spring, Maryland, 20902</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov 4, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | | 23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u> | | | |
| 24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Pumphrey, Inc.</u> | | | | ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 4 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

15708

15708

15708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--------------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 15766 | | | | | 15769 | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside | | | | | |
| c. LENGTH OF STAY IN 1b 15 days | | | | | d. STREET ADDRESS 1520 59th Avenue | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Kenneth Last Arthur | | | | | 4. DATE OF DEATH Month November Day 10 Year 19 66 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 15 March 1963 | | 9. AGE (In years last birthday) 3 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME John R. Arthur | | | | | 14. MOTHER'S MAIDEN NAME Joan Davis | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. None | | | | | |
| 17. INFORMANT The Medical Record, National Institutes of Health, Clinical Center, Bethesda, Md. | | | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Right Subclavian to Pulmonary Artery Anastomosis DUE TO (c) Pulmonary Atresia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Anastomosis 48 hours 3 yrs. 7 mo | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that Q (this hospital) attended the deceased from 26 October, 1966 , to 10 November 19 66 , that XIX (we) last saw the deceased alive on 10 November 19 66 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE Hamner Hannah III | | | | | 22b. DATE SIGNED Nov. 10, 1966 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Hamner Hannah III, M.D. | | | | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Nov. 14, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. | | | 23d. LOCATION (City, town or county) (State) Arlington, Virginia | | |
| 24. FUNERAL DIRECTOR Simmons Bros. | | | | | 25. REGISTRAR'S SIGNATURE Charles Judge | | | | | |
| ADDRESS Simmons Bros. 1661-Good Hope Rd SE Wash DC | | | | | DATE NOV 14 1966 | | | | | |

03561

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------|-------------------|--|------------------------------------|--|--|---|----------------|----------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 15767 | | | | CERTIFICATE OF DEATH | | | | 15770 | | | |
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | | |
| a. COUNTY | | | | a. STATE | | | | b. COUNTY | | | |
| Montgomery | | | | Minnesota | | | | 1 | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | | | | |
| Bethesda | | | | Minneapolis | | | | 60-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? | | | |
| The Clinical Center, Bethesda, Maryland | | | | 5620 36th Avenue, South | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | | 4. DATE OF DEATH | | | Month Day Year | | |
| Marion Ida Askerooth | | | | | | November 10, 1966 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| Female | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 27 August 1896 | | 70 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) | | | |
| Sewing Instructor | | | | Garment | | | | Minnesota | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Karl Lotti | | | | Gustava Treaux | | | | USA | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No --- | | | | 475-14-0561 | | The Medical Record | | The Clinical Center, Bethesda, Md. 20014 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Malignant Lymphoma - Mycosis Fungoides | | | | | | | | | | 1 1/2 years | |
| DUE TO (b) Right Lobar Pneumonia - probable pseudomonas | | | | | | | | | | 1 day | |
| DUE TO (c) Probable Pseudomonas Septicemia | | | | | | | | | | 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| Hour a.m. p.m. 19 | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 21. I certify that (this hospital) attended the deceased from November 18, 1965, to Nov. 10, 1966, that (we) last saw the deceased alive on November 10, 1966, and that death occurred at 6:30M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| William R. Lewis | | | | M.D. | | | | 10 November 1966 | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | | | | | |
| William R. Lewis | | | | The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) (State) | | | |
| Burial-transit | | | 11-11-66 | | Cokato Finish Cem. | | | Cokato, Minn. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 24. REC'D BY REGISTRAR | | 25. REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | | | NOV 14 1966 | | Charles Judge | |

MEDICAL CERTIFICATION

1893

1893



Minnesota

Minneapolis

327 Ave

Minneapolis

The Clinical Center, Bethesda, Maryland, 3000 Rock Avenue, Berlin

Station 1000 Rock Avenue, Berlin, Maryland, 20814

White Female 17 August 1893

Reeling Instructor, German, Minnesota

Original Source

The Medical History

175-1A-0561 The Clinical Center, Bethesda, Md. 20814

19 years Mildred Thompson - present residence

1 day Right lower extremities - probable peroneus

1 day Probable peroneus posterior

November 18, 1900

6:30

November 18, 1900

18 November 1900

The Clinical Center, Bethesda, Maryland

William R. Davis

175-1A-0561-1-1-60

Nov 1, 1900

ROBERT A. BARNHART, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15768

CERTIFICATE OF DEATH

15771

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>3419-30th St NW</u> D.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u> | | d. STREET ADDRESS <u>3419-30th St NW</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS J. BARNES</u> | | 4. DATE OF DEATH Month Day Year <u>NOVEMBER 17 1966</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 8, 1878</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sun Oil Co</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>THOMAS J. BARNES</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY MASON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>GRACE BARNES (sister)</u> | | Address <u>WASH. D.C. 3419-30th St NW</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage of penis vessel</u> 1790 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis cerebral vascular disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13, 1966</u> , to <u>11/17, 1966</u> that (I) (we) last saw the deceased alive on <u>11/17, 1966</u> , and that death occurred at <u>12</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>H F Kreuzburg</u> | | 22b. DATE SIGNED <u>11/17/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u> | | 22d. ADDRESS <u>7852 16th St NW Wash DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 21, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>West Laurel Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Lower Merion Township Mont. Pa.</u> |
| 24. FUNERAL DIRECTOR <u>Arthur Walters Washington, D.C.</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 21 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

15731

ESTIMATE OF DEATH

15731



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

68

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7

15769

15772

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15769

15772

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Montgomery**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Silver Spring** c. LENGTH OF STAY IN 1b **5 hours**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Wheaton** **151**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Holy Cross Hospital** d. STREET ADDRESS **10114 McKenney Avenue**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last **Floyd E. Barrett** 4. DATE OF DEATH Month Day Year **November 24, 19 66**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **JUNE 9, 1887** 9. AGE (In years lost birthday) **79** yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired Clerk** 10b. KIND OF BUSINESS OR INDUSTRY **Railroad** 11. BIRTHPLACE (County & State, or foreign country) **Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **James E. Barrett** 14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes give war or dates of service) **None** 16. SOCIAL SECURITY NO. **716-03-0953** 17. INFORMANT **Mabel H. Barrett** **10114 McKenney Avenue Silver Spring, Maryland**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **331X Cerebrovascular accident - Thrombosis**
DUE TO (b) **arteriosclerotic vascular disease**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) **—**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **None**

INTERVAL BETWEEN ONSET AND DEATH **4 DAYS**
10 YRS.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **11/20**, 19**66**, to **11/24**, 19**66**, that (I) (we) last saw the deceased alive on **11/24** 19**66**, and that death occurred at **4:05AM**, from causes and on the date stated above.

22a. SIGNATURE **Henry W. Stout** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED **11/24/66**

22c. PHYSICIAN'S NAME (Type) **HENRY W STOUT** 22d. ADDRESS **10011 GEORGIA AVE SILVER SPRING MD**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **Nov 28, 1966** 23c. NAME OF CEMETERY OR CREMATORY **Cedar Hill Cemetery** 23d. LOCATION (City or Town) (County) (State) **Suitland, Maryland**

24. FUNERAL DIRECTOR **John B. Thomas** **8434 Georgia Avenue** **Warner E. Pumphrey, Inc.** **Silver Spring, Md.** 25a. REC'D BY REGISTRAR **DEC 1 1966** 25b. REGISTRAR'S SIGNATURE **[Signature]**

VR A15 (14) 20 M 1/66

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MLC14704

192 JOURNAL OF DOCUMENTATION

A. J. B. (1965)

4019

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15770

CERTIFICATE OF DEATH

15773

| | | | | | |
|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Maryland) Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5300 Yorktown Road | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 5300 Yorktown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Walter Irwin Batchelder | | 4. DATE OF DEATH November 10 19 66 | | 5. AGE (In years last birthday) 84 yrs. | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (County & State, or foreign country) Vermont | |
| 13. FATHER'S NAME Robert Batchelder | | 14. MOTHER'S MAIDEN NAME Sarah J. Weatherby | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 011-16-2479-A/ | | 17. INFORMANT Lucille Batchelder - N.W. Wash. DC. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, genl. (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 min 10 yrs | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 1955 to 10 Nov 1966 that (I) (we) last saw the deceased alive on 9 Nov 1966, and that death occurred at 9:45 AM, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Herbert Martyn Jr 22c. PHYSICIAN'S NAME (Type) HERBERT MARTYN JR | | 22b. DATE SIGNED 90 Nov 66 22d. ADDRESS 4740 Chevy Chase Dr Chevy Chase Md | | 22e. REC'D BY REGISTRAR DATE NOV 18 1966 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 11-14-1966 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery Newark, Vermont | |
| 23d. LOCATION (City, town or county) (State) | | 25a. FUNERAL DIRECTOR'S SIGNATURE Joseph Charles Judge 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | |

15774

15770

Cherry Lane
Hartland

Cherry Lane
Hartland

3000 Yorkton Road

3000 Yorkton Road

Yorkton, Saskatchewan

Yorkton, Saskatchewan

1960-1961

1960-1961

Verdun

Verdun

John J. Hartland

John J. Hartland

101-1000-A, Route 1, Verdun, N.B.

101-1000-A, Route 1, Verdun, N.B.

Handwritten notes:
2 in 1960
101

11-11-1961
Removal

1960-1961
Verdun, N.B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15774

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>D.C.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>151</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>7209 - Fairfax Rd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Philip</u> First <u>A.</u> Middle <u>Bayer</u> Last | | 4. DATE OF DEATH <u>Nov.</u> Month <u>14</u> Day <u>19</u> Year <u>66</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 9, 1895</u> 71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Int. Revenue</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Philip Bayer</u> | | 14. MOTHER'S MAIDEN NAME <u>Rosk</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW2</u> | | 16. SOCIAL SECURITY NO. <u>220-44-0684</u> | |
| 17. INFORMANT <u>Mae Bayer</u> Address <u>same as above</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary Insufficiency Acute -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular Disease -</u> (c) <u>4 years</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | 22. DATE SIGNED <u>11/14/66</u> | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-18-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 21 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

MEDICAL CERTIFICATION

1975

1975

1975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15772

CERTIFICATE OF DEATH

15775

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md. | | c. LENGTH OF STAY IN 1b one week | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Washington, D.C. | | b. COUNTY Prince George | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home | | | | d. STREET ADDRESS 3206 Terrace Drive 901 Arlene Ave., Wheaton, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Reba Roberta Beaton | | | | | | 4. DATE OF DEATH Month November Day 2 Year 1966 | | | |
| 5. SEX F | | 6. COLOR OR RACE Caus. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 12/8/1910 | | 9. AGE (In years last birthday) 55 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone operator | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Seat Pleasant, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | |
| 13. FATHER'S NAME Robert C. Beaton | | | | | | 14. MOTHER'S MAIDEN NAME Mary Agnes Sommers | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 577-01-3120 | | 17. INFORMANT Address Landover, Md Maurice H. Beaton 412 Brightseat Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Heart Disease DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs 20 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 21 , 19 66 to Nov 2 , 19 66 , that (I) (we) last saw the deceased alive on Nov 2 , 19 66 and that death occurred at 12:15 PM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE William Brainin | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/2/66 | |
| 22c. PHYSICIAN'S NAME (Type) WM BRAININ | | | | | | 22d. ADDRESS 6128 Central Ave, Capitol Heights Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-5-66 | | 23c. NAME OF CEMETERY OR CREMATORY Addison Chapel Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Seat Pleasant Maryland | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland | | | | | | 25a. REC'D BY REGISTRAR NOV 4 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1973

1973

STATE OF NEW YORK

County of ...
City of ...
State of New York
I, the undersigned, Clerk of the County of ...
do hereby certify that the within and foregoing is a true and correct copy of the ...
as the same appears from the records of the County of ...
this 1st day of ... 1973.
Clerk of the County of ...
By ...
Deputy Clerk of the County of ...

...

12778

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NOV 10 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15774

CERTIFICATE OF DEATH

15777

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9811 Bristol Avenue</u> | | d. STREET ADDRESS <u>9811 Bristol Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Pearl</u> Last <u>Berry</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 16, 1878</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Newton B. Adams</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura B. Shaw</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>YES</u> | |
| 17. INFORMANT <u>Divian Cook</u> | | Address <u>9811 Bristol Avenue Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>65</u> , to <u>Nov 7</u> , 19 <u>66</u> , that (I) (was) last saw the deceased alive on <u>Nov. 5</u> , 19 <u>66</u> , and that death occurred at <u>6:30 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>William B. Wardrop</u> | | 22b. DATE SIGNED <u>11/7/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>William B. Wardrop</u> | | 22d. ADDRESS <u>800 Pershing Drive, S. S., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 11, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Bushnell Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Bushnell, Illinois</u> | |
| 24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 9 1966</u> | |
| Address <u>8434 Georgia Avenue Silver Spring, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

15771

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STATEMENT OF DEBIT

THE STATE OF NEW YORK, OFFICE OF THE COMPTROLLER, ALBANY, N.Y.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

15775

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15778

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5422 McKinley Street | | d. STREET ADDRESS 5422 McKinley Street | |
| 3. NAME OF DECEASED (Type or print) First DONALD Middle Damon Last BORG | | 4. DATE OF DEATH Month Nov. Day 27, Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/17/25 |
| 9. AGE (In years last birthday) 41 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Administrative- Real Estate | | 10b. KIND OF BUSINESS OR INDUSTRY Mass. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Ernest A. Borg | | 14. MOTHER'S MAIDEN NAME Jessica M. Damon | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes. WW II | | 16. SOCIAL SECURITY NO. 047-12-8540 | |
| 17. INFORMANT Brother Roland E. Borg | | 18. ADDRESS 3130 Wis. Ave., N.W. Washington, D. C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration + Maceration of Brain - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gun Shot Wound of Head - DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in Rt side of Head - 22 Cal. Pistol - | |
| 20c. TIME OF INJURY Month, Day, Year 5:40 p.m. 11/27 1966 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) (County) (State) Bethesda Mont. Md. |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) JOHN G. BALL | | 22. DATE SIGNED Nov. 28, 1966 Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-5-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem. | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR DATE DEC 5 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15776

CERTIFICATE OF DEATH

15779

| | | | |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) | | c. LENGTH OF STAY IN 1b 168 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Linda Middle Kay Last BOUDRIE | | 4. DATE OF DEATH Month November Day 3 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 15, 1946 |
| 9. AGE (In years last birthday) 19 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Tazewell, Tennessee | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Denver Lynch | | 14. MOTHER'S MAIDEN NAME Ruth Mason | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. 375-50-7070 | |
| 17. INFORMANT Monroe Address Michigan | | 18. Mr. Timothy Frank Boudrie, 1899 Fix Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that the (this hospital) attended the deceased from May 19 , 19 66 , to Nov. 3 , 19 66 , that he (we) last saw the deceased alive on Nov. 3 , 19 66 , and that death occurred at 910P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Peter T. Kirchner M.D. | | 22b. DATE SIGNED 4 Nov. 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Peter T. Kirchner | | 22d. ADDRESS Naval Hospital, Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - transit 11-5-66 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | | 23d. LOCATION (City or Town) (County) (State) Tazewell, Tennessee | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland | | 25a. REC'D BY REGISTRAR NOV 10 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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1993

1999

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Editorial Level

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Received 13 June 2003

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Don't miss the new 1994 Dodge Stratus.

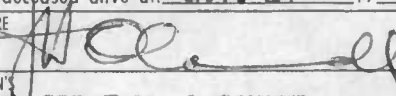
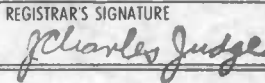
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15777

CERTIFICATE OF DEATH

15780

| | | | | | |
|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE FLORIDA b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN 1b FIVE DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILTON | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. NAVAL HOSPITAL | | | d. STREET ADDRESS 1610 OKALOOSA STREET | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last MINNIE NMN WALLS BREWTON | | | 4. DATE OF DEATH Month Day Year NOVEMBER 24 19 66 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 12 DECEMBER 1920 | | 9. AGE (In years last birthday) 45 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) MILTON FLORIDA | |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | 13. FATHER'S NAME WILLIE WALLS | | |
| 14. MOTHER'S MAIDEN NAME MAMIE MARSHALL | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 261-36-9155 | | | 17. INFORMANT Address Mrs. Bertha Larkins, 411 Econfina St., Milton Fla. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE CEREBRAL EDEMA 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STATUS POST CRANIOTOMY DUE TO (c) INTERCRANIAL NEOPLASM | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 19 , 19 66 , to Nov. 24 , 19 66 , that (I) (we) last saw the deceased alive on Nov. 24 , 19 66 , and that death occurred at 8:45 P.M. , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE  | | | 22b. DATE SIGNED Nov. 25, 1966 | | |
| 22c. PHYSICIAN'S NAME (Type) CDR F.H. O CONNEL MD | | | 22d. ADDRESS Naval Hospital, Bethesda, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11-26-66 | 23c. NAME OF CEMETERY OR CREMATORY Milton Cemetery | 23d. LOCATION (City or Town) (County) (State) Milton, Florida | | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N.W. Washington, D. C. | | | 25a. REC'D BY REGISTRAR DATE NOV 28 1966 | | 25b. REGISTRAR'S SIGNATURE  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15780

STATE OF TEXAS

1877

IN SENATE

JANUARY

1877

REPORT

OF THE

COMMISSIONERS

AND

MEMBERS

OF THE

BOARD

OF THE

STATE

OF TEXAS

FOR THE YEAR

1876

AND FOR THE YEAR 1877

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 15778 | | | | | | | | | | | | | |
| 15781 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u> | | | | | | d. STREET ADDRESS <u>1034 University Blvd., E.</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Alice C Brigham</u> | | | | | | 4. DATE OF DEATH <u>November 13 19 66</u> | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 22, 1927</u> | | 9. AGE (In years last birthday) <u>39 yrs.</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. Co. School</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>Ernest Clark</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Jessie M. Thomas</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u> | | | | 16. SOCIAL SECURITY NO. <u>578-28-3055</u> | | 17. INFORMANT <u>Leonard Brigham</u> | | Address <u>1737 Ladd St. Silver Spring, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonitis</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty metamorphosis of liver</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic alcoholism</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Belden R. Keap, M.D.</u> | | | | M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22. DATE SIGNED <u>11/15/1966</u> | | | | | |
| EXAMINER'S NAME (Type) <u>11502 Grandview Ave., Wheaton, Md.</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 17, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u> | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u> | | | | ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | DATE <u>NOV 18 1966</u> | | | | | | | |

15738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15738

STATE OF

NEW YORK

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONER

OF HEALTH

AND

HYGIENE

FOR THE

YEAR

1899

AND

FOR THE

MONTHS

OF

THE

QUARTER

ENDING

ON

DECEMBER

31, 1899

AND

FOR THE

YEAR

1898

AND

FOR THE

MONTHS

OF

THE

QUARTER

ENDING

ON

DECEMBER

31, 1898

AND

FOR THE

YEAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15779

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15782

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1220 Blair Mill Road | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1220 Blair Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Miriam Brill First Middle Last 4. DATE OF DEATH November 2 1966 Month Day Year | | 5. SEX Female 6. COLOR OR RACE Cauc. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Female 10b. KIND OF BUSINESS OR INDUSTRY Cauc. | | 11. BIRTHPLACE (County & State, or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Golieb | | 14. MOTHER'S MAIDEN NAME Russia | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 577-34-9137 | |
| 17. INFORMANT Abner L. Rosendorf | | Address Sil.Sp., Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 day 11 months years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 3, 1965 to Nov 2, 1966 , that (I) (we) last saw the deceased alive on Nov 2, 1966 , and that death occurred at 4:30 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert B. Harell M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/2/66 | |
| 22c. PHYSICIAN'S NAME (Type) Robert B. Harell | | 22d. ADDRESS 5516 Nebraska Ave. DC. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/3/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ohev Shalom Talmud Torah Cem. | | 23d. LOCATION (City, town or county) (State) Washington, D.C. | |
| 24. FUNERAL DIRECTOR Bernard Danzansky & Sons | | 25a. REC'D BY REGISTRAR St., N.W. Wash. D.C. 25b. REGISTRAR'S SIGNATURE NOV 4 1966 J. Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15780

CERTIFICATE OF DEATH

15783

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda(rural) | | | | c. LENGTH OF STAY IN 1b 20 Days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs | | | | 15-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda Naval Hospital | | | | d. STREET ADDRESS 4415 Mahan Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Margaret Alletta Brooks | | | | 4. DATE OF DEATH Month Day Year November 15 19 66 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cauc. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 26 July 1911 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Rock Island Ill. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Charles D. Snyder | | 14. MOTHER'S MAIDEN NAME Rox Pearl Fitz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Wilbur Brooks 4415 Mahan Rd. Silver Springs | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO Myelofibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that it (this hospital) attended the deceased from 27 Oct. , 19 66 , to 15 Nov. , 19 66 that it (we) last saw the deceased alive on 15 Nov. , 19 66 , and that death occurred at 5:45 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Peter T. Kirchner M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 16 November 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Peter T. Kirchner, M. D. | | | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 21, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Chippianock Cemetery | | 23d. LOCATION (City or Town) (County) (State) Rock Island, Illinois | |
| 24. FUNERAL DIRECTOR W. E. Pumphrey Funeral Home 8434 Georgia Ave., Silver Spring, Maryland John B. Thomas | | | | 25a. REC'D BY REGISTRAR NOV 18 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15780

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Non-Com

Maryland

Baltimore (Md)

SO Daye

Silver Springs

Beaumont (Tex)

1415 Mason Road

Margaret

Alabama

Prison

November

26 July 1911

Cauc.

Female

Huntsville

Alabama

Rock Island Ill.

USA

Charles H. Sargent

Good, California

to

Name

Walter Thomas 1415 Mason Rd. Silver Springs

Naval Station

Philadelphia

Peter E. Kipner, M. D.

U. S. Naval Hospital, Bethesda, Maryland

Wm. E. Cragg and Ganssery

Rock Island, Illinois

Gerald Ave., Silver Spring, Maryland

W. E. Cragg and Ganssery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15781

15784

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 27 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Purdum | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital | | | | d. STREET ADDRESS RFD # 1, Monrovia | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Delaney Middle F. Last Brown | | | 4. DATE OF DEATH Month Nov. Day 7 Year 19 66 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 23, 1888 | | 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own farm | | 11. BIRTHPLACE (County & State, or foreign country) Purdum, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Franklin Brown | | | | 14. MOTHER'S MAIDEN NAME Florence Strothers | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 219-36-2586 | | 17. INFORMANT Delaney P. Brown, Germantown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno-carcinoma of colon 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 years? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardio-vascular-renal Disease | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from January, 1935 , to Nov. 7, 1966 , that (I) (we) last saw the deceased alive on Nov. 7, 1966 , and that death occurred at 7:45 A.M. on the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE M. McKendree Boyer, M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Nov. 8, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D. | | | | 22d. ADDRESS 9701 Church Street Damascus, Maryland. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 9, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Mountain View | | 23d. LOCATION (City, town or county) (State) Purdum, Md. | |
| 24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md. | | | | 25a. REC'D BY REGISTRAR NOV 14 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

15784

15784

DEPARTMENT OF HEALTH

Nov. 7, 1960

Nov. 7, 1960

Nov. 7, 1960

Nov. 7, 1960

2701 Church Street
Baltimore, Maryland

Mr. Robert M. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|------------------|-------------------|--|------------------------------------|---|---|--------------------------------------|---------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 15782 | | | | | | 15785 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY | | | Montgomery | | | a. STATE | | | b. COUNTY | | |
| | | | MARYLAND | | | | | | Maryland Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| Olney | | | | 7 days. | | Brinklow | | | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Montgomery General Hospital | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | |
| Ernest Brown | | | | | | Nov. 29 1966 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | Negro | | | | 5-7-18 | | 48 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| Laborer | | | | Landscape | | Maryland | | | | USA | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Albert Brown | | | | | | Maggie Robinson Robinson | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | |
| (Yes, no, or unknown) | | | | (If yes give war or dates of service) | | Montgomery Gen. Hospital | | | | Olney, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.1 General peritonitis, chemical | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perforated duodenal ulcer | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 19 | | | | | | 1963 11/29 | | 66 | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/28/66 to 12/29/66, that (I) (we) just saw the deceased alive on 12/28/66, and that death occurred on 12/29/66 from causes on and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | 22b. DATE SIGNED | | | | | |
| Dr. Charles Ligon | | | | | | 11/29/66 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | |
| Dr. Charles Ligon | | | | | | Sandy Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) (County) (State) | | | | |
| BURIAL | | | 12/2/66 | | Ash Memorial | | Sandy Spring, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert L. Snowden | | | | | | DATE DEC 7 1966 | | Charles Judge | | | |

2575

77:23
77:24

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15786

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>37 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium "Ind. Hospital"</u> | | d. STREET ADDRESS <u>404 Bryant Mills Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Minnie</u> Last <u>Brown</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-5-95</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday) <u>71</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry Gearhart</u> | | 14. MOTHER'S MARDEN NAME <u>Margaret Beisinger</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Resp. Records</u> Address |

| | | | |
|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Branch pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>chronic bron syndrome, urinary tract infection</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>Nov. 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 24</u> , 19 <u>66</u> , and that death occurred at <u>7:58</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>R. H. Sandstrom M.D.</u> | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u> | 22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md.</u> | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | 23b. DATE THEREOF <u>11/28/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u> | 23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u> |
| 24. FUNERAL DIRECTOR <u>Lee Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |
| ADDRESS <u>300 4th st. N.E. Washington, D.C.</u> | | DATE <u>NOV 30 1966</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12788

EXHIBIT 12788

Blank lined paper with a large rectangular box on the right side. The box contains faint, illegible text. There are two black circular marks on the right edge of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
item 9 Film G385 12/6/66 mh

15784

CERTIFICATE OF DEATH

15787

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOM. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 31 Yrs | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 114 IDA LORENA | | d. STREET ADDRESS Box 114 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First RENA Middle IDA Last BROWN | | 4. DATE OF DEATH Month 11 Day 30 Year 1966 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/18/1892 74 yrs. |
| 9. AGE (In years lost birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF. | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Montgomery Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME CHARLES A. GARTRELL | | 14. MOTHER'S MAIDEN NAME VIRGINIA S. GROOMS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212 24 4950 | |
| 17. INFORMANT HUSBAND | | Address SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSELEROTIC HEART DISEASE (c) YRS. | | INTERVAL BETWEEN ONSET AND DEATH SUDDEN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE C.V. DISEASE: CHRONIC NEPHRITIS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from OCT , 19 64 , to 11/30 , 19 66 , that (I) (we) last saw the deceased alive on 11/31 , 19 66 and that death occurred at 6A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Donald R. Lewis | | 22b. DATE SIGNED 11-30-66 | |
| 22c. PHYSICIAN'S NAME (Type) DONALD R. LEWIS M.D. | | 22d. ADDRESS OLNEY, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 2 1966 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel | 23d. LOCATION (City or Town) (County) (State) Sunshine Mont. Md. |
| 24. FUNERAL DIRECTOR Francis H. Barber ADDRESS Laytonsville Md. | | 25a. REC'D BY REGISTRAR DATE DEC 2 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | |

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Laytonville Md.

Francis J. Barber

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15785

CERTIFICATE OF DEATH

15788

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 2 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ROSE Middle ELLEN Last BROWNE | | 4. DATE OF DEATH Month NOV. Day 22 Year 1966 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/27/1894 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months 13 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (County & State, or foreign country) Rockville, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James P. McGowan | | 14. MOTHER'S MAIDEN NAME Mary Burns | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT JAMES B. BROWN | | Address 11301 Farmland Dr., Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X METASTASIS TO CEREBRUM, ADENOCARCINOMA DUE TO (b) ADENOCARCINOMA BREAST DUE TO (c) 4 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSION, ESSENTIAL | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/24 , 1966, to 11/22 , 1966, that (I) (we) last saw the deceased alive on 11/22 , 1966, and that death occurred at 7:45 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE James A. Roberts | | 22b. DATE SIGNED 11/22/66 | |
| 22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS | | 22d. ADDRESS 8907 GED. AVE. SILVER SPRING, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 26, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR Clark E. Wisor | | 25a. REC'D BY REGISTRAR NOV 25 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, 1511</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8907 Flower Avenue</u> | | d. STREET ADDRESS <u>8907 Flower Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>H</u> Last <u>Brunner</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 13, 1901</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Atty.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Milan, Indiana</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Milton E. Bruner</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Henthorn</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>Yes</u> | |
| 17. INFORMANT <u>Marie H. Bruner</u> | | Address <u>8907 Flower Avenue Silver Spring, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Heart Dis.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular disease</u> DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>6 Nov, 1966</u> , that (I) (we) lost saw the deceased alive on <u>Nov 10</u> 1966, and that death occurred at <u>4:55</u> P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dr. H. Tablin</u> | | 22b. DATE SIGNED <u>11/7/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. H. Tablin</u> | | 22d. ADDRESS <u>800 Pershing Drive, S. S., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 10, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 9</u> 1966 | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0025-5718

2952

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

15787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15790

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|---|----------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY - <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>26720 Ridge Rd</u> | | d. STREET ADDRESS <u>26720 Ridge Rd</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Sorathy</u> Middle <u>Nelle</u> Last <u>Burdette</u> | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>1966</u> | |
| 5. SEX <u>Fe-</u> | 6. COLOR OR RACE <u>W-</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 28, 1909</u> |
| 9. AGE (In years lost birthday) <u>56</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>18</u> Days <u>13</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Kensington, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>C. Mack Burdette</u> | | 14. MOTHER'S MAIDEN NAME <u>Lola Young</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs James K. Day, Silver Spring, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute fatty metamorphosis of liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obesity</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Recent</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | 22. DATE SIGNED <u>11/25/66</u> | |
| EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/27/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 28 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

15780

15780

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15788

CERTIFICATE OF DEATH

15791

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|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> | | c. LENGTH OF STAY IN 1b <u>S.O.A.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u> | | d. STREET ADDRESS <u>1006 Massachusetts Avenue, N.E.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Burns</u> Last <u>Burns</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 8, 1894</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>11</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Genealogist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>James A. Walker</u> | | 14. MOTHER'S MAIDEN NAME <u>Sallie Hansard</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>400-28-8145</u> | |
| 17. INFORMANT <u>McGhee</u> Address <u>118 Fleetwood Terrace Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>YEAR</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/12, 1966</u> , to <u>4/17, 1966</u> that (I) (we) last saw the deceased alive on <u>4/12, 1966</u> and that death occurred at <u>8 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>F. W. Schneider</u> M.D. | | 22b. DATE SIGNED <u>11/8/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Frederick Schneider</u> | | 22d. ADDRESS <u>201 8th St., N. E., Wash., D. C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 10, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Methodist Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Saundersville, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Glen Carter</u> Address <u>8434 Georgia Ave. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 9 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared with As Keep 11-8-66

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE
HEALTH DEPT.

15789

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15792

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only one case within 72 hours after death.

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|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN lb -2-days 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Michigan b. COUNTY 59.3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Farmington d. STREET ADDRESS 26550 Badalament Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Douglas Middle M. Last BYERS | | 4. DATE OF DEATH Month November Day 20 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 11 1944 |
| 9. AGE (In years last birthday) 22 yrs. | | 10. IF UNDER 1 YEAR Months 22 Days 11 Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 11. BIRTHPLACE (State or foreign country) Nebraska | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Merwin D. Byers | | 14. MOTHER'S MAIDEN NAME Larene Beighley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Farmington Address Michigan Merwin D. Byers, 26550 Badalament Court | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive fracture base of skull with hemorrhage 8244 DUE TO with lacerations of brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 28 hours (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-Accident-Thrown out of car | |
| 20c. TIME OF INJURY Month, Day, Year 11/19 1966 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) Quantico (County) Va. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John G. Ball M.D. | | 22. DATE SIGNED 11/21/66 | |
| EXAMINER'S NAME (Type) John G. Ball, M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/23/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Andrews Cemetery | | 23d. LOCATION (City or Town) Friend (County) Nebraska (State) | |
| 24. FUNERAL DIRECTOR Washington ADDRESS D. C. | | 25. REGISTRAR'S SIGNATURE Charles Judge | |
| W. W. Chambers Co., 1400 Chapin St., N.W. | | DATE NOV 25 1966 | |

80521

0022-2720

15790

CERTIFICATE OF DEATH

15793

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | c. LENGTH OF STAY IN 1b DOA | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | | | d. STREET ADDRESS 14106 London Lane | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First William Middle Daniel Last Cahill Jr. | | | | 4. DATE OF DEATH Month November Day 15 Year 1966 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/29/86 | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City clerk | | | 10b. KIND OF BUSINESS OR INDUSTRY City government | | 11. BIRTHPLACE (County & State, or foreign country) Marlboro, Massachusetts | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Morris ? Cahill | | | | 14. MOTHER'S MAIDEN NAME Mary Kane | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None | | | 16. SOCIAL SECURITY NO. 032-01-4655 | 17. INFORMANT Daughter, Mrs. Gladys Johncox | | Address 14106 London Ln Rkvl., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 10, 1966 to Nov 15, 1966 that (I) (we) last saw the deceased alive on Nov 15, 1966 and that death occurred at 9:15 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John J. Curry | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/15/66 | |
| 22c. PHYSICIAN'S NAME (Type) John J. Curry, M.D. | | | | 22d. ADDRESS 10620 Ga. Ave. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 18, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cem. Marlboro, Massachusetts | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR C. Glen Carter Warner & Humphrey, Inc. | | ADDRESS C. Glen Carter, 8434 Georgia Ave. Silver Spring, Md. | | 25a. REC'D BY REGISTRAR NOV 18 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

Cleared with Medical Examiner's Office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15791

15794

| | | | | | | | |
|--|------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | c. LENGTH OF STAY IN 1b <u>2 mos. 3 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Chase Nsg & Convalescent Center</u> | | | | d. STREET ADDRESS <u>532 PEABODY STREET</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>THOMAS F CALLAHAN, SR</u> First Middle Last | | | | 4. DATE OF DEATH Month <u>NOV.</u> Day <u>22</u> Year <u>1966</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>9-26-1876</u> | | 9. AGE (In years last birthday) <u>90</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEPT. of Agriculture - until retirement</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, DC</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, DC</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JAMES A. CALLAHAN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY MC CARTHY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(UNKNOWN)</u> | | 16. SOCIAL SECURITY NO. <u>579-32-2868</u> | | 17. INFORMANT Address <u>SEE ITEM 2.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior-cerebral Heart Disease</u> (c) <u>—</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13</u> , 19 <u>66</u> , to <u>Nov 22</u> , 19 <u>66</u> , that (I) (<u>not</u>) last saw the deceased alive on <u>Nov 22</u> , 19 <u>66</u> , and that death occurred at <u>535 p.m.</u> from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>James W. Egan</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/22/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. James W. Egan</u> | | | | 22d. ADDRESS <u>7720 Wisc. Ave. Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-26-1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph Cawler's Sons, Inc.</u> | | | | 25a. REC'D BY REGISTRAR <u>Wash. D.C.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Nov 29 1966</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

12301

STATE OF TEXAS

12301

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MARYLAND STATE DEPARTMENT OF HEALTH

- Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15792

CERTIFICATE OF DEATH

15795

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>1916 Brisbane Street</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLT CROSS HOSPITAL</u> | | d. STREET ADDRESS <u>SILVER SPRING MD</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MICHAEL A CARTA</u> | | 4. DATE OF DEATH Month Day Year <u>11 28 1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>CAUC</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/2/06</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. <u>11 26</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Repair</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>577-28-6387</u> | |
| 17. INFORMANT <u>Joan C. Toriano - daughter</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible shock</u> DUE TO (b) <u>Myocardial infarct</u> DUE TO (c) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u> <u>2-3 days</u> <u>4 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>66</u> , to <u>11/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>66</u> , and that death occurred at <u>12:45</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Richard P. Delaney</u> | | 22b. DATE SIGNED <u>11/28/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u> | | 22d. ADDRESS <u>4323 Havard St., Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, or other disposal <u>BURIAL</u> | 23b. DATE THEREOF <u>12/1/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, d.</u> |
| 24. FUNERAL DIRECTOR <u>Wheeler</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

112542

2025

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15793

CERTIFICATE OF DEATH

15796

| | | | |
|--|---------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 7 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle Edward Last CARTER | | 4. DATE OF DEATH Month November Day 7 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 14, 1966 |
| 9. AGE (In years last birthday) 54 | | 10. IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min. 54 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Lee Carter | | 14. MOTHER'S MAIDEN NAME Joyce Hulsey | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no | | 16. SOCIAL SECURITY NO. N/A | |
| 17. INFORMANT Mr. Lee Carter, 34 Anderson Court | | Address Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral pneumonia DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Subdural hematoma, left. Encephalomalacia, marked. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 31 , 19 66 , to Nov. 7 , 19 66 that (x) (we) last saw the deceased alive on Nov. 7 , 19 66 , and that death occurred at 8:00 A , from causes and on the date stated above. | | | |
| 22a. SIGNATURE A. E. TOMPKINS | | 22b. DATE SIGNED Nov 8, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) A. E. TOMPKINS, M.D. | | 22d. ADDRESS Naval Hospital, Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-11-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fayetteville Cemetery | | 23d. LOCATION (City or Town) (County) (State) Sylacauga, Alabama | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland | | 25a. REC'D BY REGISTRAR NOV 14 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

6-222935

12730

12733

Maryland

Maryland

Lexington Park

7 days

Referral (trial)

3d Assistant Court

Naval Hospital

November 7

GALE

Edward

John

24

Dept. of Justice

Case

Main

USA

Patent Office, Maryland

W/A

W/A

John H. H. H.

Law Center

Maryland

Lexington Park

Mr. Law Center, 3d Assistant Court

W/A

W/A

no

Historical Association

Episcopal Seminary, 1812, Independence, Kansas

Oct. 31

Nov. 7

Oct. 31

Naval Hospital, Bethesda, Maryland

A. J. TOWNE, M.D.

Albany, Alabama

Robert A. Ramsey, General House

1111 Wisconsin Ave., Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15794

CERTIFICATE OF DEATH

15797

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>3304 Oberon Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Emil</u> Middle <u>Ephraim</u> Last <u>Ceder</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-7-92</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Gustaf Eric Peterson</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Son - Robert Ceder - same as above</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE LUNG</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>66</u> to <u>11/21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/21</u> 19 <u>66</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Richard H. Pollen</u> | | 22b. DATE SIGNED <u>11/22/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u> | | 22d. ADDRESS <u>10400 CONNECTICUT AVE, KENSINGTON, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| <u>Burial-transit</u> | <u>11-22-66</u> | <u>Lutheran Cemetery</u> | <u>Arnot, Penna.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 25 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

12325

RECORDS OF DEATH

12325

HOSPITAL

DATE

TIME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

ACUTE CAUSE

CHRONIC CAUSE

INTERMITTENT CAUSE

RECURRENT CAUSE

PROGRESSIVE CAUSE

STAGNANT CAUSE

OBSTRUCTED CAUSE

PERMEABLE CAUSE

IMPERMEABLE CAUSE

SEMI-IMPERMEABLE CAUSE

HYPERPERMEABLE CAUSE

HYPOPERMEABLE CAUSE

ISOPERMEABLE CAUSE

ANISOPERMEABLE CAUSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>4/6-11/1966</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland Nursing Home, 1000 Calverview Dr., Silver Spring, Md.</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>3420 16th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lela McGrath Chaffee</u> First Middle Last | | | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1966</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Cauc.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/13/1887</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary National Metropolitan Bank</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u> | | |
| 13. FATHER'S NAME <u>J.G. McGrath</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Hickey</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes no unknown</u> | | | | 16. SOCIAL SECURITY NO. <u>579-60-4124</u> | | 17. INFORMANT <u>Mrs. Mary VAIK</u> Address <u>Ridgewood, New Jersey</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>4200</u> OUE TO <u>3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>2 1/2 yrs.</u> (c) <u> </u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1964</u> , to <u>Nov-29, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 29, 1966</u> and that death occurred at <u>10 A-M</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Neil P. Campbell</u> | | | | | | 22b. DATE SIGNED <u>Nov. 29, 1966</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u> | | | |
| 22d. ADDRESS <u>1629 Columbia Rd.</u> | | | | | | 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE THEREOF <u>12/1/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u> | | | |
| 24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u> | | | | | | 25a. NOV 30 1966 | | | | | |

15308

15308

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15796

CERTIFICATE OF DEATH

15799

| | | | |
|--|---------------------------|--|------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>thru 25 mins</u> <u>Conf as tota</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>113 - S. Main St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Raffaelie Cimino</u> | | 4. DATE OF DEATH <u>11 - 3</u> 19 <u>66</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1882</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe repair</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Giovanni Cimino</u> | | 14. MOTHER'S MAIDEN NAME <u>LISA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>062-28-87A</u> | |
| 17. INFORMANT <u>Son-in-law - McRory/Sans</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRO VASCULAR ACCIDENT</u> DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS</u> <u>4 HRS</u> <u>5 HRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2 Nov</u> , 19 <u>66</u> , to <u>3 Nov</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2 NOVEMBER 19 66</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Ronald Barr</u> | | 22b. DATE SIGNED <u>11-3-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Ronald Barr</u> | | 22d. ADDRESS <u>10401 Old Georgetown Rd Bethesda Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-7-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulcher</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Rochester New York</u> | |
| 24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS <u>4308 Suitland Rd Suitland Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 7 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

1952

4252

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

FOR STATE
HEALTH DEPT.

15797

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15800

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|---|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8027 Eastern Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Anne Middle M Last Clark | | 4. DATE OF DEATH Month 11 Day 20 Year 1966 | |
| 5. SEX female | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/4/26 25 |
| 9. AGE (In years last birthday) 39 yrs. | | 10. IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture | |
| 11. BIRTHPLACE (State or foreign country) Scottdale, Pa. | | 12. CITIZEN OF WHAT COUNTRY US | |
| 13. FATHER'S NAME George H. Clark | | 14. MOTHER'S MAIDEN NAME Regina Nash | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 199-16-9585 | |
| 17. INFORMANT Mr George H. Clark | | Address 11301 Farmland Drive Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465x Acute bilateral pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 years DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Belden R. Reap M.D. | | 22. DATE SIGNED Nov. 20, 1966 | |
| EXAMINER'S NAME (Type) BELDEN R. REAP M.D. | | Address (Street, City, Town, or County) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/23/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville, Pike Rockville, Md. | | 25a. REC'D BY REGISTRAR NOV 22 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15798

CERTIFICATE OF DEATH

15801

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPRINGFIELD</u> | | c. LENGTH OF STAY IN 1b <u>14 YEARS.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPRINGFIELD</u> | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5304 BROOKWAY DRIVE</u> | | d. STREET ADDRESS <u>5304 BROOKWAY DRIVE</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>MR GILBERT CHURCH CLARK</u> | | 4. DATE OF DEATH <u>NOV 22</u> 19 <u>66</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC 27, 1897</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>LIFE INSURANCE WASHINGTON, D.C.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>GILBERT A. CLARK</u> <u>577-05-7068</u> | | 14. MOTHER'S MAIDEN NAME <u>ROSA MARCIA CHURCH</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WAR #1</u> <u>1917-1921</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>WIFE</u> | | Address <u>SAME</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA.</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>BRONCHOGENIC CARCINOMA</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>1 MOS.</u> <u>4 MOS.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>55</u> , to <u>NOV 22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>NOV 22</u> , 19 <u>66</u> , and that death occurred at <u>12:35 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Lawrence A. Rapee</u> M.D. | | 22b. DATE SIGNED <u>Nov. 22, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE A. RAPEE</u> | | 22d. ADDRESS <u>1732 EYE ST NW WASH. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-25-1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5150 Wisconsin Ave. N.W., Wash. DC.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 23 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE | |

12801

CERTIFICATE OF DEATH

18502

12801

DO NOT WRITE OR SIGN IN THESE SPACES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15799

CERTIFICATE OF DEATH

15802

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b 48 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mrs. Bessie First NMN Middle Cohen Last | | 4. DATE OF DEATH November 11, 1966 Month 11 Day 11 Year 19 66 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/1/1892 B. DATE OF BIRTH unknown |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? America | |
| 13. FATHER'S NAME Isaac Unknown Frank Dynafesky | | 14. MOTHER'S MAIDEN NAME xxxxxx Rachel | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Patient's chart | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Congestive heart failure and DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Cerebral atherosclerosis - Diverticulosis coli - Anemia | | | |
| 19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m. | | 20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20d. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-26, 1966 , to 11-14, 1966 that (I) two last saw the deceased alive on 11-13 1966 and that death occurred at 12:15 A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Gilbert Hurwitz | | 22b. DATE SIGNED 11-14-66 | |
| 22c. PHYSICIAN'S NAME (Type) GILBERT HURWITZ, M.D. | | 22d. ADDRESS 1800 - Eye St. N.W. Wash. D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 11-15-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY CHEV SHELOM - TALMUD TORAH | | 23d. LOCATION (City or Town) (County) (State) Washington, D.C. | |
| 24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASHINGTON - D.C. | | 25. REC'D BY REGISTRAR NOV 17 1966 | |
| 26. REGISTRAR'S SIGNATURE Charles Judge | | | |

15802

CERTIFICATE OF DEATH

15802

Blank form with horizontal lines for text entry.

MADE IN U.S.A. BY THE NATIONAL BUREAU OF STANDARDS
WASHINGTON, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 15800 | | | | | | 15803 | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 1 Year d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 113 Hesketh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Annie Bailey Cook | | | | | | 4. DATE OF DEATH Nov. 1 1966 | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 3, 1883 | | 9. AGE (In years last birthday) 82 | | IF UNDER 1 YEAR Months 10 Days 28 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) Mississippi | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME John A. Bailey | | | | | | 14. MOTHER'S MAIDEN NAME Walterine G. McClung | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 218-54-8339 | | 17. INFORMANT Grand Daughter Dorothy E. Kuster | | | | 18. ADDRESS 265 Congressional Ave. Rockville, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 4331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular fibrillation DUE TO (c) Arteriosclerosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. None p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from prior to 1966 to present 1966, that (I) (we) last saw the deceased alive on 10/31/1966 , and that death occurred 11/1/66 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE John B. Umhau | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/1/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) JOHN B. UMHAU | | | | | | 22d. ADDRESS 8805 Conn. Ave. Chevy Chase, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-4-66 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | | | 23d. LOCATION (City, town or county) (State) Rockville, Maryland | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | 25a. REC'D BY REGISTRAR NOV 7 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9, 12, 14 Film G383 11/28/66 mh

15801

CERTIFICATE OF DEATH

15804

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>TEXAS</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Terrell</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Helen E.</u> Middle <u>CORLEY</u> Last <u>11-10</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1897</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Terrell Texas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry G. Haring</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah H. Burrison</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>451-22-5386</u> | |
| 17. INFORMANT <u>Charles Corley</u> | | Address <u>7208 OLD STAGE RD. Rockville</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon with invasion of</u> DUE TO <u>mesentery and duodenum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1538</u> (c) <u>6-mo</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6-mo</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/1/1966</u> to <u>11/10/1966</u> , that (I) (we) last saw the deceased alive on <u>11/10/1966</u> , and that death occurred at <u>6:45 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert C. Macon</u> | | 22b. DATE SIGNED <u>11/10/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert C. Macon</u> | | 22d. ADDRESS <u>809 Viers Mill Rd, Rockville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>11/10/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Terrell</u> | 23d. LOCATION (City or Town) (County) (State) <u>Terrell, Texas</u> |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> <u>Rockville, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10802

10802

[Faint, illegible handwriting and markings across the page, possibly bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15802

CERTIFICATE OF DEATH

15805

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.R. GEORGE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | | c. LENGTH OF STAY IN 1b <u>26 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN.</u> | | d. STREET ADDRESS <u>5719 29th Ave Apt. 204</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>(NMN)</u> Last <u>COSMAN</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/22/95</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DIAMOND CO.</u> | 9. AGE (In years last birthday) <u>71</u> |
| 11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | |
| 13. FATHER'S NAME <u>JACK COSMAN</u> | | 14. MOTHER'S MAIDEN NAME <u>SARAH HAMBURG</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>579-07-7894</u> | |
| 17. INFORMANT <u>P.T. CHART</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>26 days</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Congestive Heart Failure, Glaucoma</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from <u>10-22, 1966</u> , to <u>11-17, 1966</u> , that (1) (we) last saw the deceased alive on <u>11/17</u> 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Alan R. Gair</u> | | 22b. DATE SIGNED <u>11/17/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALAN R. GAIR M.D.</u> | | 22d. ADDRESS <u>7777 Maple Ave, Takoma Park, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>11/20/1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u> | 23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH, VA.</u> |
| 24. FUNERAL DIRECTOR <u>GOLDENEG FUNERAL Home 4717 9th St. N.W.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 21 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15807

INSTITUTE OF DESIGN

15803

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15803

CERTIFICATE OF DEATH

15806

| | | | |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>4 1/2 hrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>5906 Kingsford Place</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Giuseppe</u> First <u>Cossavella</u> Middle <u></u> Last <u></u> | | 4. DATE OF DEATH <u>11</u> Month <u>10</u> Day <u>1966</u> Year | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 15 1891</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Stephen Cossavella</u> | | 14. MOTHER'S MAIDEN NAME <u>Carlotta Fornero</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1917 WW I</u> | | 16. SOCIAL SECURITY NO. <u>240-07-6454</u> | |
| 17. INFORMANT <u>Ursula C Millhron</u> Address <u>Same as above</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction recent and remote with</u> <u>4201</u> DUE TO <u>Ventricular aneurysm.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>66</u> to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 1965</u> and that death occurred at <u>6:10 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W. E. Hermant</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11-11-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Walter B. E. Hermant MD</u> | | 22d. ADDRESS <u>11125 Rockville Pike Rockville, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-14-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| 26. DATE <u>NOV 14 1966</u> | | 27. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

12803

12803

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15804

CERTIFICATE OF DEATH

15807

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> | |
| c. LENGTH OF STAY IN 1b <u>50 MIN</u> | | d. STREET ADDRESS <u>11201 Falls Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis</u> <u>John</u> <u>COUREMBIS</u> | | 4. DATE OF DEATH Month Day Year <u>Nov</u> <u>7</u> <u>1966</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>CAUC</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 8, 1889</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Louis Courembis</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Terras</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>578-16-7469</u> | |
| 17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u> | | 18. MOTHER'S MAIDEN NAME <u>Dorothy W. Courembis</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerosis Heart Disease</u> DUE TO (c) <u>5 hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>11/4</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/4</u> 19 <u>66</u> and that death occurred at <u>4:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Herman Courembis</u> M.D. | | 22b. DATE SIGNED <u>11/4/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Herman Courembis</u> | | 22d. ADDRESS <u>50 W. Edmonston Dr. Rockville, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-8-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 10 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15807

DEPARTMENT OF HEALTH

15804

15807

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|----------------------------------|---|--|--|--|---|--|--|---|--|
| 15808 | | | | | 15808 | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | |
| a. COUNTY <u>Montgomery</u> MARYLAND | | | | | a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | | | |
| c. LENGTH OF STAY IN 1b <u>DOA</u> | | | | | d. STREET ADDRESS <u>7201 Barnett Road</u> | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Herbert August Crandell</u> | | | First Middle Last | | 4. DATE OF DEATH <u>November 3 1966</u> | | Month Day Year | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8 March 1908</u> | | 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scientist</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Frank Crandall</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Susan Coffin</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | 16. SOCIAL SECURITY NO. <u>1942-46</u> | | 17. INFORMANT <u>The Medical Records</u> | | Address <u>The Clinical Center, Bethesda, Maryland</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>3561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Amyotrophic lateral sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u> <u>3 Years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3 Nov.</u> , 19 <u>66</u> , to <u>3 Nov.</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>(DOA) 3 Nov 19 66</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Jon D. Dorman</u> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>3 November 1966</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Jon D. Dorman, MD</u> | | | | | 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>11-7-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | | 23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u> | | | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR <u>NOV 7 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

MEDICAL CERTIFICATION

15802

15802

U.S. Government

(C)

11-7-02

Washington, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15806

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15809

- FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | | | c. LENGTH OF STAY IN 1b 5 DAYS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First RAMIE Middle NONE Last CRUM | | | | 4. DATE OF DEATH Month 11 Day 22 Year 19 66 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-11-25 | |
| 9. AGE (In years last birthday) 41 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JESSE HICKS | | 14. MOTHER'S MAIDEN NAME PANSY - LAST NAME UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MEDICAL RECORDS DEPT. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe, extensive, burns DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of over 35% of body surface DUE TO (c) due to fire. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased burned while attempting to light stove at home. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 7:00 a.m. 11-17 1966 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Brookeville, Montgom. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Belden R. Read | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) BELDEN R. READ M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 11/25/66 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Burman Cem. | | | | 23d. LOCATION (City or Town) (County) (State) Bakersville, N.C. | | | |
| 24. FUNERAL DIRECTOR Dyson Wheeler Funeral Home | | | | 25a. REC'D BY REGISTRAR NOV 25 1966 | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | 22. DATE SIGNED Nov. 23, 1966 | | | |

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12-11-17

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

15807

15810

| | | | |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>9202 - Cedarlane</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Wilma C. Curtin</u> | | 4. DATE OF DEATH <u>Nov. 25 1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 7, 1902</u> |
| 9. AGE (In years last birthday) <u>63</u> | | 10. IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>govt.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Anthony Redpath</u> | | 14. MOTHER'S MAIDEN NAME <u>Edna Schapp</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>096-01-7812</u> | |
| 17. INFORMANT <u>Bernard Curtin</u> | | Address <u>3936 Woodlawn, Silver Spring</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Severe Arteriosclerosis</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | 22. DATE SIGNED <u>11/26/66</u> | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11/29/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 30 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15810

15810

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

15841

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15844

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>4840 - Chevy Chase</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>(Daly)</u> Last <u>Daly</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>May 28, 1907</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Dist. of Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Andrew Wilbur Starratt</u> | | 14. MOTHER'S MAIDEN NAME <u>Carrie Bland Perkins</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Andrew Starratt</u> | | Address <u>217 - South St. Rockville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>5721</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Peritonitis</u> DUE TO (c) <u>Diverticulitis with rupture, sigmoid colon</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED <u>12/1/66</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county) <u>Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12-3-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>DEC 5 1966</u> | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

15841

Examination of the

15841

Examination of the

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|---|-------------------------------------|--|---|--|--|--|--------------------------------|--|--|---|--|--|--|--|---|--|--|--|--|
| 15808 | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | 15811 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville | | | | | c. LENGTH OF STAY IN 1b Years. | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville, Maryland 15.1 | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1120 Allison Drive | | | | | d. STREET ADDRESS 1120 Allison Drive | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Frank C. Darcey | | | | | 4. DATE OF DEATH November 29 1966 | | | | | | | | | | | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/8/1901 | | 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days Min. | | IF UNDER 24 HRS. Hours Min. | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME William E. Darcey | | | | | 14. MOTHER'S MAIDEN NAME --- Blunden | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 577-10-3588 | | | | | 17. INFORMANT Wife - Virginia G. Darcey Address same item #2 | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. 4/20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden. | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | 22. DATE SIGNED Nov. 29, 66 | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) John G. Ball | | | | | 7936 Old Geo. Rd. Bethesda, Md. Address (Street, city, town, or county) | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9/29/66 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE THEREOF 12/1/66 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | | | | 23d. LOCATION (City, town or county) (State) Rockville, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler | | | | | | | | | | ADDRESS 1331 Rockville Pike Rockville, Maryland | | | | | 25a. REC'D BY REGISTRAR DATE DEC 1 1966 | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | |

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15308

4/8/1901

Maryland

Catenary Insufficiency Aids

John D. Bell

X 4/10/1901

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15809

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15812

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u> | | d. STREET ADDRESS <u>1720 KEOKEE ST.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>ERNEST C. DARDEN</u> | | 4. DATE OF DEATH <u>Nov. 12 1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-3-13 53</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during month of working life, even if retired) <u>Book Keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Junco Markets Inc</u> | 11. BIRTHPLACE (State or foreign country) <u>N. Car</u> |
| 13. FATHER'S NAME <u>Robert Darden</u> | | 14. MOTHER'S MAIDEN NAME <u>Lula Ann Lamm</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>579-12-3122</u> | |
| 17. INFORMANT <u>Glady D. Fitzwater</u> | | Address <u>11435 Schuyler Rd., Rockville</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute coronary thrombosis with infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, allie bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>Nov. 13, 1966</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u> | 23b. DATE THEREOF <u>Nov. 15, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> | 23d. LOCATION (City or Town) (County) (State) <u>Ft. Geo. Co., Md.</u> |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers & Co Inc</u> | | 25a. REC'D BY REGISTRAR <u>NOV 17 1966</u> | |
| ADDRESS <u>8655 Ga. Ave Silver Spring, Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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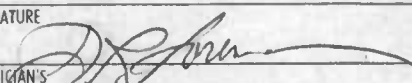
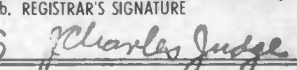
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15810

CERTIFICATE OF DEATH

15813

| | | | | | | | |
|--|------------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) | | | c. LENGTH OF STAY in 1b 55 Days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden, Md. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 3314 Hayes Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Abraham Middle (NMN) Last Dawson | | | | 4. DATE OF DEATH Month November Day 5 Year 19 66 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negroid | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 17, 1926 | | 9. AGE (In years last birthday) 40 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Joplin, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Abraham Dawson | | | | 14. MOTHER'S MAIDEN NAME Unkown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Carrie B. Dawson 3314 Hayes St. Glenarden, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 12 , 1966, to Nov. 5 , 1966, that (I) (we) last saw the deceased alive on Nov. 5 , 1966, and that death occurred at 7:47 AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) D.R. Foreman MD | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U.S. Naval Hospital, Bethesda, Md. | | 22b. DATE SIGNED Nov. 5, 1966 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-10-1966 | | 23c. NAME OF CEMETERY OR CREMATORY Cemetery Arlington National Cemetery | | 23d. LOCATION (City or Town) (County) (State) Arlington Va. | |
| 24. FUNERAL DIRECTOR Jarvis Funeral Home, 1432 U St. NW, Washington DC | | | | 25a. REC'D BY REGISTRAR DATE NOV 14 1966 | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Journal of Management Education 32(1)

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15811

CERTIFICATE OF DEATH

15814

| | | | |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) | | c. LENGTH OF STAY in 1b 52 Days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | d. STREET ADDRESS 22 Pine Street, AFB Trailer Pk. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Gregory Middle Alan Last Diamond | | 4. DATE OF DEATH Month November Day 20 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April, 11, 1963 |
| 9. AGE (In years last birthday) 3 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant - None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas A. Diamond | | 14. MOTHER'S MAIDEN NAME Geri Louise N. Férá | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Thomas A. Diamond Andrews AFB, Maryland. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage, right 7551 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular malformation of cerebellum DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Bronchial pneumonia, lower lobes | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 19 66 , to Nov. 20, 19 66 that (I) (we) last saw the deceased alive on Nov. 20, 19 66 , and that death occurred at 630 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Jerry J. Tomasovic | | 22b. DATE SIGNED 21 Nov. 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M. D. | | 22d. ADDRESS Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-23-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington Va. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR R.A. Pumphery Funeral Home Bethesda, Maryland | | 25a. REC'D BY REGISTRAR NOV 25 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | 25c. REGISTRAR'S NAME Charles J. [Signature] | |

15812

15812

U.S. Naval Hospital

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San Francisco

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT

15812

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15815

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>20 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4103 Hewitt Avenue</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15.1</u> d. STREET ADDRESS <u>4103 Hewitt Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Lester Earle Dixon</u> First Middle Last 4. DATE OF DEATH <u>11 - 26 19 66</u> Month Day Year | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 17, 1893</u> 9. AGE (In years last birthday) <u>73 8/8</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Auditor of Oil Co.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u> 11. BIRTHPLACE (State or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Ulysses S. Dixon</u> 14. MOTHER'S MAIDEN NAME <u>Eliza Callerton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WWII</u> 16. SOCIAL SECURITY NO. <u>577-36-9255</u> 17. INFORMANT Address <u>Mrs. Eleanor A. Wertman 8 Center Ave. Muncy, Pa.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u></u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | 20f. (City or town) (County) (State) <u></u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | 22. DATE SIGNED <u>Nov. 27, 1966</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 29, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Nov 30 1966</u> | |

15815

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W.W.I

JOHN R. PROFFER

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15813

CERTIFICATE OF DEATH

15816

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiloh Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u> | | d. STREET ADDRESS <u>12618 Flack Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First <u>Doane</u> Middle <u>NOT</u> Last | | 4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 21, 1966</u> |
| 9. AGE (In years last birthday) yrs. <u>15-1</u> | | IF UNDER 1 YEAR Months <u>24</u> Days <u>50</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Clyde Doane</u> | | 14. MOTHER'S MAIDEN NAME <u>Mildred Olinger</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>-</u> | | Address <u>-</u> | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immature Birth, Neonatal Death</u> 7730 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> (c) <u>-</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> |
| 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 21, 1966</u> to <u>Nov. 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 22, 1966</u> , and that death occurred at <u>7:30 p.m.</u> from causes and on the date stated above. | | |
| 22a. SIGNATURE <u>Frank W. Neuberger</u> | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED <u>Nov. 22, 1966</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>FRANK W. NEUBERGER</u> | 22d. ADDRESS <u>1110 Spring Street, Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u> | 23b. DATE THEREOF <u>Nov. 24-1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Doane Cemetery, Saltville, Va.</u> |
| 23d. LOCATION (City or Town) (County) (State) | | |
| 24. FUNERAL DIRECTOR <u>Arthur Waters</u> | ADDRESS <u>254 Carroll St. N.W.</u> | DATE <u>Nov 25 1966</u> |
| 25. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15813

STATE OF NEW YORK

15813

RECEIVED
JUL 11 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15814

15817

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 hr 30 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fabertown, Maryland</u> d. STREET ADDRESS <u>12618- FLACK STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Twinn Girl No. 2</u> First Middle Last <u>Doane</u> | | 4. DATE OF DEATH Month Day Year <u>11 21 1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-21-66</u> |
| 9. AGE (In years last birthday) yrs. <u>4</u> IF UNDER 1 YEAR Months <u>4</u> Days <u>30</u> IF UNDER 24 HRS. Hours <u>4</u> Min. <u>30</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | |
| 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland USA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? — | | 13. FATHER'S NAME <u>CLYDE H. DOANE</u> | |
| 14. MOTHER'S MARDEN NAME <u>MILDRED OLINGER</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>CLYDE H. DOANE</u> | |
| 17. INFORMANT <u>CLYDE H. DOANE</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>7545</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>7545</u> DUE TO (c) <u>7545</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital Heart Disease</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/21/66</u> 19 <u>66</u> to <u>11/21/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/21/66</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stanley I. Wolf</u> M.D. | | 22b. DATE SIGNED <u>11/21/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Stanley I. Wolf MD</u> | | 22d. ADDRESS <u>1110 Spring St S.W. Spring Md</u> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Nov. 24-1966 Deane Cemetery</u> | | 23b. DATE THEREOF <u>Nov. 24-1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Deane Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Saltville - Va.</u> | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Watters Washington D.C.</u> | | 25. RECD BY REGISTRAR <u>NOV 25 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

51251

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15815

15818

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>10 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. and Hosp.</u> | | d. STREET ADDRESS <u>2115 Drexel ST</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Maitland Dolan Sr.</u> | | 4. DATE OF DEATH Month Day Year <u>November 8 1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>Sept. -27, 1901</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpet</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Dolan</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Piper</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u> | | 16. SOCIAL SECURITY NO. <u>577-09-1218A</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive Heart Failure</u> DUE TO <u>5271</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>For advanced pulmonary emphysema</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 months</u> <u>3 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/8</u> , 19 <u>65</u> , to <u>11/8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/7</u> 19 <u>66</u> , and that death occurred at <u>9:30</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE SIGNED <u>11/8/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HUGH W. IREY</u> | | 22d. ADDRESS <u>7105 Riggs Rd (Lewisiana) Hyattsville, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>Nov. 12, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington Va</u> |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers</u> | | 25a. REC'D BY REGISTRAR <u>5. Iver Spring MA.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | DATE <u>NOV 10 1966</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15812

ESTIMATE OF DEATH

15812

RECEIVED
JAN 10 1961
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15816

15819

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| c. LENGTH OF STAY IN lb <u>9 days</u> | | d. STREET ADDRESS <u>604 Falls Road</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel Lillian Lane</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/3/05</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> | 11. IF UNDER 24 HRS. Hours <u>14</u> Min. <u>15</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Vernon Hill</u> | | 14. MOTHER'S MAIDEN NAME <u>Bessie Johnson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>4201</u> | |
| 17. INFORMANT <u>Katherine Trayman</u> Address <u>604 Falls Road Rockville Md.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ARTERIO SCLEROTIC HEART DISEASE</u> | |
| 19. INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u> | | 20. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>8 DAYS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/6/66</u> , 19 <u>66</u> , to <u>11/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>66</u> , and that death occurred at <u>8:15</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas F. O'Connor</u> | | 22b. DATE SIGNED <u>11/15/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR</u> | | 22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>11/18/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg, Md.</u> |
| 24. FUNERAL DIRECTOR <u>George R. Snowden</u> ADDRESS <u>Rockville Md</u> | | 25. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 18 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1281

31831

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15817

CERTIFICATE OF DEATH

15820

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> | |
| c. LENGTH OF STAY IN 1b <u>18 days</u> | | d. STREET ADDRESS <u>4206 Stanford St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Statterer</u> Last <u></u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1965</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>Cau</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-19-92</u> |
| 9. AGE (In years lost birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Federal Gov.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Moore</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Joseph C. Statterer</u> | | Address <u>Manassas Va.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>161X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to carcinoma, larynx</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u></u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u></u> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> , 19 <u>65</u> to <u>11/9</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>11/9</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> P.M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>J. Blaine Fitzgerald</u> M.D. | | 22b. DATE SIGNED <u>11/11/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. Blaine Fitzgerald</u> | | 22d. ADDRESS <u>8218 Wisconsin Avenue Bethesda</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>11-11-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> DATE | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12820

RECEIVED

12817

RECEIVED
JAN 11 1961
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15818

CERTIFICATE OF DEATH

15821

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germanatown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marylander Nursing Home | | d. STREET ADDRESS 118- Iroquois Way | |
| 3. NAME OF DECEASED (Type or print) GRACE E. DOWNING | | 4. DATE OF DEATH Nov. 2nd 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 1st 1900 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR Months 10 Days 2 Hours 2 Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 11b. KIND OF BUSINESS OR INDUSTRY Penna. | |
| 12. BIRTHPLACE (County & State, or foreign country) Penna. | | 13. CITIZEN OF WHAT COUNTRY? USA | |
| 14. FATHER'S NAME John Downing | | 15. MOTHER'S MAIDEN NAME Christine Schirm | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 17. SOCIAL SECURITY NO. Same as | |
| 18. INFORMANT Mrs. Edith M. Moyer (Sister) | | Address # 2. | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Friedreich's Ataxia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH years years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) advanced premature senility | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/12 , 19 65 to Nov 2 , 19 66 , that (I) (we) last saw the deceased alive on Nov 2 , 19 66 , and that death occurred at 2:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE John G. Fawcett M.D. | | 22b. DATE SIGNED 11/2/66 | |
| 22c. PHYSICIAN'S NAME (Type) John G. Fawcett | | 22d. ADDRESS Dawsonville, Maryland. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Nov. 5-1966 | 23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | 23d. LOCATION (City or Town) (County) (State) Altoona, Pa. |
| 24. FUNERAL DIRECTOR Simmons Bros. | | 25a. REC'D BY REGISTRAR DATE NOV 4 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15881

15881

GRACE
Downing

Frederick's
Literature

occasional
prominent

John J. Toward

15881

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CLEARED BY MEDICAL EXAMINER

1
15819
M
68
15822
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | c. LENGTH OF STAY IN 1b 1 DAY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holy Cross Hospital | | | | d. STREET ADDRESS 525 Third Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Holland Middle O. Last Draper | | 4. DATE OF DEATH Month November 2, Day 19 Year 66 | | 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/21/08 | | 9. AGE (In years lost birthday) yrs. 58 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Controller | | 10b. KIND OF BUSINESS OR INDUSTRY J. & L. Corp. Mines | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Arthur Draper | | | | 14. MOTHER'S MAIDEN NAME Helen B. (Unknown) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Yes | | 17. INFORMANT Helen B. Draper Address 525 Third Street California, Pennsylvania | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL RUPTURE 4201 DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN | | | | | | INTERVAL BETWEEN ONSET AND DEATH MOMENTARY ONE DAY UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/1 19 66 , to 11/2 19 66 , that (I) (we) last saw the deceased alive on 11/2 19 66 , and that death occurred at 4 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard H. Pollen | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/2/66 | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN | | | | 22d. ADDRESS 10400 CONN. AVE, KENSINGTON MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. , 1966 | | 23c. NAME OF CEMETERY OR CREMATORY LaFayette Memorial Park | | 23d. LOCATION (City, town, or county) (State) Brier Hill, Fayette City, Pa. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Clark E. Wisor (Clark E. Wisor) | | | | 25a. REC'D BY REGISTRAR NOV 4 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| 24. ADDRESS Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | | | | |

RECEIVED JANUARY 11 1943

12319

CERTIFICATE OF DEATH

12319

Montgomery

Pennsylvania

Silver Spring

California

Holy Cross Hospital

315 Third Street

Holland

Prager

November 2

Male

White

2/11/18

33

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item 2 Film G382 11/18/66 kb

15820

CERTIFICATE OF DEATH

15823

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 ~~1~~
 Examiner MLloyd
 Medical Certification 2
 Cleared 2 Medical

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon, Md.</u> d. STREET ADDRESS <u>1002 Annapolis Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Florence Dunlap</u> | | | 4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1966</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-10-85</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>YWC A. Staff</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>III</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Jacobsville. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Melville S. Dunlap</u> | | | 14. MOTHER'S MAIDEN NAME <u>Laura B. Jacobs</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT Address <u>Gaithersburg</u> <u>Asbury Methodist Home Records. Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive HEART FAILURE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Several yrs.</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>66</u> , to <u>11/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> , 19 <u>66</u> , and that death occurred at <u>4 P.M.</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Richard H. Pollen</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>11/13/66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u> | | | | 22d. ADDRESS <u>10900 CONNECTICUT AVE, KENSINGTON, MD</u> | | | |
| 23a. BURIAL (CREMATION) REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>11/14/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lucretia</u> | 23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Md.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Ernest C. Gertner</u> | | | ADDRESS <u>Gaithersburg Md</u> | 25a. REC'D BY REGISTRAR DATE <u>NOV 16 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

15883

CERTIFICATE OF DEATH

15883

RECEIVED
FEB 10 1964
U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------------|--|--|---|-------------------------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 15821 | | | | | 15824 | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery SILVER SPRING b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARYLAND c. LENGTH OF STAY IN 1b 16-2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES SEAFORD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 1500 FOREST GLEN RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First KAREN Middle MECHELLE Last DUNN | | | | | 4. DATE OF DEATH Month 11 Day 15 Year 1966 | | | | | | | | | | | | | | | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-18-66 | | 9. AGE (In years last birthday) 28 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (County & State, or foreign country) Silver Spring Md. | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | | | |
| 13. FATHER'S NAME JAMES LEE DUNN | | | | | 14. MOTHER'S MAIDEN NAME KAREN GILBERT | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. NONE | | | | | 17. INFORMANT ETHEL L. DUNN Address 4109 MITZEROTT RD, COLLEGE PK. MD | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 7573 DUE TO (b) Dorsal Rachianitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Congenital absence of kidney | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1966 , to Nov 15, 1966 , and that (I) (we) last saw the deceased alive on Nov 15, 1966 , and that death occurred at 10 P M, from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Salvatore Battiatra | | | | | | | | | | 22b. DATE SIGNED 11/15/66 | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) SALVATORE BATTIATA MD. | | | | | | | | | | 22d. ADDRESS 1000 LEBANON ST. SILVER SPRING, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | 23b. DATE THEREOF 17 Nov 1966 | | | | | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | | | | | 23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co | | | | | | | | | | ADDRESS 2000 Riverdale, Maryland | | | | | 25. REC'D BY REGISTRAR NOV 21 1966 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

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Handwritten text, possibly a signature or name, appearing upside down.

Handwritten signature or name.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15822

CERTIFICATE OF DEATH

15825

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 47.3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Manor Health Care Center | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2122 California St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CLARENCE SEDGWICK DURAND First Middle Last 4. DATE OF DEATH Nov. 9 19 66 Month Day Year | | 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9-3-1879 9. AGE (In years last birthday) yrs. 87 IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Statistician-U.S. Govt. 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. 11. BIRTHPLACE (County & State, or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Henry Law Durand 14. MOTHER'S MAIDEN NAME Isabel Balm | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - - - 16. SOCIAL SECURITY NO. - - - - - 17. INFORMANT Mrs. Mildred McCormick-See Item #2 Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia-bil. DUE TO (b) Electrocardiogram DUE TO (c) Pleural Effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Nov 3 19 66 to Nov 9 19 66 saw the deceased alive on Nov 9 19 66 , and that death occurred at 9:30 M, from causes and on the date stated above. | | 21. I certify that (I) (this hospital) attended the deceased from Nov 3 19 66 to Nov 9 19 66 that (I) (we) last saw the deceased alive on Nov 9 19 66 , and that death occurred at 9:30 M, from causes and on the date stated above. | |
| 22a. SIGNATURE Robert T. Thibadeau 22c. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU 22d. ADDRESS 11,000 OLD GEORGETOWN RD 20852 | | 22b. DATE SIGNED Nov 9, 1966 MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-14-1966 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City or Town) (County) (State) Suitland, Md. | | 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. Address 500 Wisc. Ave. N.W. Wash. DC 25a. REC'D BY REGISTRAR NOV 18 1966 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15823

CERTIFICATE OF DEATH

15826

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaside</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>8219-Harry Pl.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Charles H. Ecker</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/16/199</u> |
| 9. AGE (in years last birthday) <u>66</u> Yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u>16</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tax Consultant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles E. Ecker</u> | | 14. MOTHER'S MAIDEN NAME <u>Jessie F. Ecker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>213-36-1277</u> | |
| 17. INFORMANT <u>E. L. Ecker</u> | | Address <u>8219 Harry Pl. Cherry Chase Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute antero-septal myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 years</u> (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> , to <u>Nov 3, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 3, 1966</u> , and that death occurred at <u>7:15 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert N. Coale</u> | | 22b. DATE SIGNED <u>Nov 3, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u> | | 22d. ADDRESS <u>4429 Bradley Lane Cherry Chase Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 8, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | 23d. LOCATION (City or Town) (County) (State) <u>Ft. Myer, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |
| DATE <u>NOV 9 1966</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12828

CHURCH OF DEATH

12828



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. After please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

70

VR A15 (4)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15824

CERTIFICATE OF DEATH

15827

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|--|-----------------------------|--|-----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>13 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | | d. STREET ADDRESS <u>9316 Elmhurst Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J.</u> Last <u>Edy</u> | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1966</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Can</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/30/1894</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John W. Edy in Brown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>W.K.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>457-42-2374</u> | | 17. INFORMANT <u>John V. Edy</u> | | Address <u>9316 Elmhurst Dr. Bethesda, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Acute Congestive Failure</u> DUE TO (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Diabetic Mellitus & Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>5 Days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetic Gangrene</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11</u> , 1966, to <u>Nov. 23</u> , 1966, that (I) (we) last saw the deceased alive on <u>Nov. 23</u> , 1966, and that death occurred at <u>9:25 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Robert G. Angle</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/23/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE,</u> | | | | 22d. ADDRESS <u>5009-DeRay Ave, Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>11-25-1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> | | | | ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| | | | | DATE <u>NOV 29 1966</u> | | 25b. REGISTRAR'S SIGNATURE | |

12887

UNITED STATES OF AMERICA

12887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|-----------------------------------|---|--|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 15825 CERTIFICATE OF DEATH 15828 | | | | | | | | | |
| Items 2, 14 Film G-583 11/29/66 mh | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg Rankin | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 106 Russell Ave nue | | | | | d. STREET ADDRESS 106 Russell Avenue 402 N. Main St. | | | | |
| 3. NAME OF DECEASED (Type or print) LOUELLA D. EELLS | | | | | 4. DATE OF DEATH Nov. 5, 1966 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/22/72 | | 9. AGE (In years last birthday) 94 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Illinois | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Martin P. Droll | | | | | 14. MOTHER'S MAIDEN NAME Bertha Hohlfield | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. 216-38-5853 | | 17. INFORMANT Mrs Bertha E. Irvin Item # 2 | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1966 , to Nov. 5, 1966 , that (I) (we) last saw the deceased alive on Nov. 2, 1966 , and that death occurred at 10:00 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Jack Schumacher M.D. | | | | | | 22b. DATE SIGNED 11-5-66 | | 22c. PHYSICIAN'S NAME (Type) Jack Schumacher | |
| 22d. ADDRESS 105 Russell Ave., Gaithersburg, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit | | | 23b. DATE THEREOF 11/6/66 | | 23c. NAME OF CEMETERY OR CREMATORY Rankin Union Cemetery | | | 23d. LOCATION (City, town or county) (State) Rankin, Illinois | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | | | | | 25a. REC'D BY REGISTRAR NOV 10 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15826

15829

| | | | |
|---|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | d. STREET ADDRESS <u>1610 Parkman Pl</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San Hosp - Takoma Park</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Florence Kaye Everett</u> | | 4. DATE OF DEATH <u>11/3/66</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 4 1889</u> |
| 9. AGE (In years, month, day, min.) <u>77 yrs</u> | | IF UNDER 1 YEAR: Months <u>11</u> Days <u>3</u> Hours <u>19</u> Min. <u>66</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Nashville Tenn</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Walter Scott Kaye</u> | | 14. MOTHER'S MAIDEN NAME <u>Bertha Shercock</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Yes</u> | |
| 17. INFORMANT <u>Yates</u> Address <u>1610 Parkman Pl Silver Spring Ind</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholera Myocarditis Recomp</u> 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis Senile Scurvy</u> DUE TO (c) <u>Cholera Myocarditis Hypertension</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>65</u> , to <u>11/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>66</u> , and that death occurred at <u>234</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Howard T Morse</u> | | 22b. DATE SIGNED <u>11/3/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse</u> | | 22d. ADDRESS <u>7630 Carroll Ave Takoma Park Ind</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 7, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Glen Carter Warner E. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 7 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared = Dr. Reap

12836

CERTIFICATE OF BIRTH

12836

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--------------------------------------|---|---|---|--|---|-------------------------------------|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 15827 | | | | | | 15830 | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | | c. LENGTH OF STAY IN 1b <u>10/28/66 11/2/66</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>1511</u> | | | | d. STREET ADDRESS <u>1113 ARCOLA AVE.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NOLLY CROSS Hospital</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>PAUL</u> <u>ANTHONY FAHEY</u> | | | First Middle Last | | | 4. DATE OF DEATH <u>NOV. 12 1966</u> | | | Day Year | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/28/66</u> | | 9. AGE (In years last birthday) <u>16 days</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY COUNTY, MARYLAND</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JEREMIAH F. Fahey</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE Dowling</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Jeremiah Fahey (Same as #2)</u> | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anencephalic</u> <u>750X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/29, 1966</u> to <u>11/2, 1966</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> 19 <u>66</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED <u>11/12/66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT MONES</u> | | | | | | 22d. ADDRESS <u>1110 Spring St., Silver Spring, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>11-14-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | | 23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc. 8434 Ga., Ave., S.S. Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>[Signature]</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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15231

DEPARTMENT OF HEALTH

Hospital

Admission

Admission

Admission (see p. 12)

Admission

Admission

Admission

Admission

Admission

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Admission

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Admission

Admission



CERTIFICATE OF DEATH

Reg. Dist. No.

15831

15828

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery, MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen-Mar Park | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen-Mar Park | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5202 Carlton St. | | | | d. STREET ADDRESS 202 Carlton St. | | | |
| 3. NAME OF DECEASED (Type or print) First Amalia Middle M. Last Faulkner | | | | 4. DATE OF DEATH Month November Day 25 Year 1966 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cauc. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 25, 1878 | |
| 9. AGE (In years day birthday) yrs. 88 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Charles Co., Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William B. Fergusson | | | | 14. MOTHER'S MAIDEN NAME Charlotte A. Compton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 321-01-5142 | | 17. INFORMANT Mrs. Thelma C. Roy (Same as Item 2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis nephritis DUE TO (c) Arterio sclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week 5 yrs 20 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 7 Dec , 19 64 to 25 Nov , 19 66 , that I last saw the deceased alive on 24 Nov , 19 66 and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. DATE SIGNED ACTUAL SIGNATURE W S Murphy M.D. PHYSICIAN'S NAME (Type) William S. Murphy Rockville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/28/66 | | 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Rockville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons | | | | 24a. REC'D BY REGISTRAR DEC 1 1966 | | 24b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15829

CERTIFICATE OF DEATH

15832

| | | | | | | | | | | | | | |
|--|--|--------------------------------------|--|--|--|--|--|---|--|---|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6048 Rossmore Drive</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pa. & Md</u> b. COUNTY <u>Lycoming</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6048 Rossmore Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth (none) Fessler</u> | | | | 4. DATE OF DEATH Month Day Year <u>Nov. 15 1966</u> | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 2, 1873</u> | | 9. AGE (In years last birthday) <u>93</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Benjamin Bahner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Moore</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>RA 239037</u> | | | | 17. INFORMANT Address <u>Daughter 6048 Rossmore Drive</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident - probably</u> (b) <u>Thrombosis</u> (c) <u>Arterio-sclerosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none</u> 19 <u>66</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (his hospital) attended the deceased from <u>Nov 16</u> , 19 <u>66</u> to <u>present</u> , that (I) (his) last saw the deceased alive on <u>Oct 22</u> , 19 <u>66</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Allen J. O'Neill</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/15/1966</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u> | | | | | | 22d. ADDRESS <u>8601 Old Georgetown Rd Bethesda Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 11-16-66</u> | | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY <u>Wildwood Cemetery</u> | | | | 23d. LOCATION (City, town or county) <u>Williamsport, Penna.</u> | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

03021

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15830

CERTIFICATE OF DEATH

15833

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ZAKONA PARK</u> c. LENGTH OF STAY in lb <u>13 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & HOSP.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD 151</u> d. STREET ADDRESS <u>2417 SEMINARY RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>JOHN SOTHORON FICKLING</u> | | | | 4. DATE OF DEATH <u>NOV. 5 19 66</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-14-93</u> | |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT DIRECTOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>LAND DISPOSAL</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. AMERICAN</u> | | | | 13. FATHER'S NAME <u>CHARLES FICKLING</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>IDA Rodia</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>ARMY WWI Yes</u> | | | |
| 16. SOCIAL SECURITY NO. <u>Yes</u> | | | | 17. INFORMANT <u>Leila Fickling</u> Address <u>2417 Seminary Rd. Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Leukemia type?</u> DUE TO <u>2043</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Approx 6 months</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 4, 19 64</u> to <u>Nov 5, 19 66</u> that (I) (we) last saw the deceased alive on <u>11-4 19 66</u> and that death occurred at <u>7:55 AM</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Gilbert B. Cushner</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11-5-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Gilbert B. Cushner</u> | | | | 22d. ADDRESS <u>6480 New Hampshire Ave., Jk. Pk., Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 8, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>8434 Georgia Ave.</u> | | | | 25a. REC'D BY REGISTRAR <u>NOV 9 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| <u>Warner E. Humphrey, Inc.</u> | | | | <u>Silver Spring, Md.</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15883

15883

Acute leukemia

Robert B. Cantor

11-4

22

July 2, 1964

X

11-2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15831

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15834

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u> 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>6510 96th. St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Annie M. Fisher</u> | | 4. DATE OF DEATH <u>11-15</u> 19 <u>66</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-27-1909</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u> | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frank B. Walker</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma M. Stacks</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Daughter</u> Add <u>2601 Weisman Rd</u> | | <u>Mrs. Charles Kuster</u> <u>Wheaton, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Acute</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis - Left Artery</u> 48 hr. (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/15/66</u> | |
| | | Address (Street, city, town, or county) <u>Bethesda, Md.</u> | |
| 22. DATE SIGNED | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-18-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 21 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18831

18831

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15835

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | c. LENGTH OF STAY IN 1b Silver Spring | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | | | d. STREET ADDRESS 136 Claybrook Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Errol P. Flood | | | | 4. DATE OF DEATH Month November Day 23 Year 1966 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-25-1897 | | 9. AGE (In years last birthday) yrs. 69 | | IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME William P. Flood | | | | 14. MOTHER'S MAIDEN NAME Lizzie E. Kerper | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. 578-40-9835 | | 17. INFORMANT T Mildred F. Flood Address Same as # " " | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarction DUE TO (b) with thrombosis, left Circumflex Artery DUE TO (c) Arteriosclerotic Heart Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap M.D. | | | | 22. DATE SIGNED Nov. 23, 1966 | | | |
| EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 131-11 48th St. Wash. D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 11/26/1966 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION (City or Town) (County) (State) Switzland, Md. | |
| 24. FUNERAL DIRECTOR Robert A. Mattingly ADDRESS 131-11 48th St. Wash. D.C. | | | | 25a. RECD BY REGISTRAR NOV 25 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

15832

15832

Barryland
River Station

Barryland
River Station

200 Claybrook Drive

200 Claybrook Drive

200 Claybrook Drive

200 Claybrook Drive

200 Claybrook Drive

Part of the property
with the river, left
the river, left the river

Barryland
River Station

Barryland
River Station

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15833

CERTIFICATE OF DEATH

15836

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN lb <u>19 Days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>12408 Conn. Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Harold Douglass</u> First Middle Last | | 4. DATE OF DEATH <u>Nov. 26</u> Month Day Year | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/9/09</u> 9. AGE (In years last birthday) <u>57</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Dept</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harold D. Fox, Jr.</u> | | 14. MOTHER'S MAIDEN NAME <u>A. Lillian Hughes</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>U.S. Navy</u> | | 16. SOCIAL SECURITY NO. <u>215-05-6270</u> | |
| 17. INFORMANT <u>Brother-Carlos-O. Fox</u> | | <u>4420 GREENWICH PKWY, NW WASH, DC</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular Failure - 1 hr.</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Anteroseptal Myocardial Infarct</u> DUE TO (c) <u>4 weeks</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, allie bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-7</u> , 19 <u>66</u> , to <u>11-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-26</u> , 19 <u>66</u> , and that death occurred at <u>6:30 AM</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>William Frank</u> | | 22b. DATE SIGNED <u>11-26-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK, M.D.</u> | | 22d. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 29, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| <u>Warner E. Humphrey, Inc.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE DEC 1 1966 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

19834

36851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 15834 CERTIFICATE OF DEATH 15837 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE XXXXXXXXXXXX b. COUNTY Md. Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8107 Eastern Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) SAMUEL FRIED | | | | | | 4. DATE OF DEATH Month 11 Day 7 Year 1966 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Cauc. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH /83 | | 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor | | | | 10b. KIND OF BUSINESS OR INDUSTRY Poland | | | | 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | | |
| 13. FATHER'S NAME ----- | | | | | | 14. MOTHER'S MAIDEN NAME ----- | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. ----- | | | | 17. INFORMANT Mrs. Mollie Koonin, 3126 Brooklawn Ter. Ch. Ch. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO (b) ----- Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Insufficiency | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to Nov. 7 , 19 66 , that (I) (we) last saw the deceased alive on 11/6 , 19 66 and that death occurred at 1:30 P.M. , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Samuel Desoff | | | | | | 22b. DATE SIGNED 11/7/66 | | 22c. PHYSICIAN'S NAME (Type) SAMUEL DESOFF | | | |
| 22d. ADDRESS 1302-18th St. N.W. Wash. D.C. | | | | | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 11/9/66 | | 23c. NAME OF CEMETERY OR CREMATORY Tifereth Israel Cemetery Washington, D.C. | | | | 23d. LOCATION (City, town or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons N.W. Wash., D.C. | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR Charles Judge | | | | | | 25b. REGISTRAR'S SIGNATURE NOV 10 1966 | | | | | |

15883

CERTIFICATE OF DEATH

15883

W. A. JONES, JR., M.D., M.P.H.

W. A. JONES, JR., M.D., M.P.H.

of the State of

of the State of

County of

County of

City of

City of

State of

State of

Dec. 1, 1955

Dec. 1, 1955

Age

Age

Sex

Sex

Marital Status

Marital Status

Occupation

Occupation

Education

Education

Religion

Religion

Place of Birth

Place of Birth

Date of Birth

Date of Birth

Time of Death

Time of Death

Place of Death

Place of Death

Signature of Physician

Signature of Physician

Signature of Registrar

Signature of Registrar

Signature of Coroner

Signature of Coroner

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15835

CERTIFICATE OF DEATH

15838

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park, Md.</u> | | c. LENGTH OF STAY IN 1b <u>16-2</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u> | | d. STREET ADDRESS <u>1406 University Bld.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Etta Friedland</u> | | 4. DATE OF DEATH Month Day Year <u>11 27 1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1898 68</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retail sales</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>retail sales</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Ab Samuel Gilbert</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | |
| 17. INFORMANT <u>Albert Friedland</u> | | Address <u>11014 Cone La. Silver Spring</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>coronary sclerosis</u> (b) <u>Hypertension</u> DUE TO <u>Hypertension</u> (c) <u>Hypertension</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>12 yrs</u> <u>20 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1951</u> , 19 <u>66</u> , to <u>11-27</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-17</u> , 19 <u>66</u> , and that death occurred at <u>1:09 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dr. S. Blumenthal M.D.</u> | | 22b. DATE SIGNED <u>11-27 66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>LESTER BLUMENTHAL</u> | | 22d. ADDRESS <u>5315 COND. AVS. NW</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>11/28/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. ARARAT CEM.</u> | 23d. LOCATION (City or Town) (County) (State) <u>PINELAWN L.I. N.Y.</u> |
| 24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR <u>4217-9th ST. N.W.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>NOV 30 1966</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15836 CERTIFICATE OF DEATH 15839

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|---|----------------------------------|--|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b 13 hr 40 min | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium 2nd Hospital | | | | d. STREET ADDRESS 505 Eisner St | |
| 3. NAME OF DECEASED (Type or print) William Wolf Friedman | | 4. DATE OF DEATH Month 11 Day 10 Year 1966 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-18-16 | 9. AGE (In years last birthday) 50 yrs. | IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Film Buyer | | 10b. KIND OF BUSINESS OR INDUSTRY Sidney Lust Theatre N.Y. city N.Y. | | 11. BIRTHPLACE (County & State, or foreign country) America | |
| 13. FATHER'S NAME Max Friedman | | 14. MOTHER'S MAIDEN NAME Unknown by wife | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. WW2 124-10-273 | | 17. INFORMANT Hospital Record | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION, ACUTE (c) CORONARY ARTERY DISEASE, CHRONIC | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION OBESITY PROBABLE DIABETES | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) SPONTANEOUS | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-9 , 19 66 to 11-10 , 19 66 that (I) (we) last saw the deceased alive on 11-10 , 19 66 , and that death occurred at 7:40 AM , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE John L. Ford | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11-10-66 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN L. FORD MD | | 22d. ADDRESS 831 UNIVERSITY BLVD R SILVER SPRING MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 11/13/66 | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden Falls Ch., Va. | |
| 24. FUNERAL DIRECTOR Bernard Danzansky & Sons | | ADDRESS 3501-14th St., N.W. Wash. D.C. | | 25. REC'D BY REGISTRAR NOV 14 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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Mr. [illegible]

[illegible]

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[illegible]

[illegible]

John L. Ford

631 UNIVERSITY BLVD E SIKING

Cleared with Medical Examiner JDM.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15837

CERTIFICATE OF DEATH

15840

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|--|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | | c. LENGTH OF STAY IN 1b <u>15-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & Hosp.</u> | | d. STREET ADDRESS <u>6 CRESCENT PLACE</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTHER BIRCH FROOM</u> | | 4. DATE OF DEATH Month Day Year <u>11 - 8 1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>12-1-88</u> |
| 9. AGE (In years lost birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>CANADA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>FENTON</u> | | 14. MOTHER'S MAIDEN NAME <u>BIRCH</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>MR. LE ROY FROOM</u> | |
| 17. INFORMANT <u>SAME</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Coronary Occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) <u>New 8</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 29 1966</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above. | | 22a. SIGNATURE <u>Wilford D Meyers MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22b. DATE SIGNED <u>Nov 8, 1966</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Wilford D Meyers MD</u> | |
| 22d. ADDRESS <u>8323 Haddon Dr. Takoma Park Md</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE THEREOF <u>Nov. 12. 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u> | |
| 23d. LOCATION (City or Town) (County) (State) <u>Adelphi. Pr. Geo. Co. Md</u> | | 24. FUNERAL DIRECTOR: <u>Arthur Walters</u> ADDRESS <u>257 Carroll St NW. Wash DC</u> | |
| 25a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J Charles G...</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15838

15841

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Silver Spring | | c. LENGTH OF STAY IN 1b 1 year 1 month | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home 901 Arcola Ave. | | d. STREET ADDRESS 6815 Red Top Road | |
| 3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Fry | | 4. DATE OF DEATH November 23 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Caus. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 4, 1871 |
| 9. AGE (In years last birthday) 94 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Ret. Clerk, Receiving | | 10b. KIND OF BUSINESS OR INDUSTRY D. C. Transit Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) Loudoun County, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Daniel Fry | | 14. MOTHER'S MAIDEN NAME Adelaide Marche | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. S. S. N578-10-6408 | |
| 17. INFORMANT Rachel Kennedy | | Address 6815 Red Top Road Takoma Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 10-23 , 19 65 , to 11-22 , 19 66 , that (I) (we) last saw the deceased alive on 11-22 19 66 , and that death occurred at 9:03 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Irwin H. Ardan | | 22b. DATE SIGNED 11-23-66 | |
| 22c. PHYSICIAN'S NAME (Type) IRWIN H. ARDAN, M.D. | | 22d. ADDRESS 1712 - I - ST, N.W. WASH, D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Nov. 26, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 23d. LOCATION (City or Town) (County) (State) Washington, D. C. |
| 24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc. | | 25. REC'D BY REGISTRAR NOV 28 1966 | |
| ADDRESS 8434 Georgia Ave. Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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University, Lansing, Mich. 48906-1000

John Thomas, 1881

London, Ontario, Canada

Hotel

U.S. 10-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Certification

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|-----------------------------------|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15839 | | | | CERTIFICATE OF DEATH | | | 15842 | | |
| 1. PLACE OF DEATH Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Md Prince Georges | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium | | | | d. STREET ADDRESS 3207 Castle Leigh Rd | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) George Arthur Fyfe | | | | 4. DATE OF DEATH 11 6 66 | | | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-29-1913 | | 9. AGE (In years (birthdays) yrs. 53 | |
| 10a. USUAL OCCUPATION (Give kind of work done during week ending nearest date, even if retired) Director | | 10b. KIND OF BUSINESS OR INDUSTRY Boys Club | | 11. BIRTHPLACE (County & State, or foreign country) Girardville, Penna. | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Charles Fyfe | | | | 14. MOTHER'S MAIDEN NAME Edith Jull | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. 579-38-9254 | | 17. INFORMANT Mrs. Marion Fyfe 3207 Castle Leigh Rd Beltsville, Md. wife (same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1964, 19, to 11-6, 1966 that (I) (we) last saw the deceased alive on May 1966, and that death occurred at 9:55 AM, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE R. H. Sandstrom | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11-6-66 | | | |
| 22c. PHYSICIAN'S NAME (Type) R. H. Sandstrom M.D. | | | | 22d. ADDRESS 7711 Carroll Ave Takoma Park, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF Nov. 9, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory | | | 23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md. | | |
| 24. FUNERAL DIRECTOR C. Glen Carter Warner & Pumphrey, Inc. | | | | ADDRESS 8434 Georgia Ave Silver Spring, Md | | 25a. REC'D BY REGISTRAR DATE NOV 9 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove labels, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15840

15843

| | | | | | | | |
|---|------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Dickerson, Md.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in-hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u> <u>POTOMAC VALLEY RD - ROCKVILLE</u> | | | | d. STREET ADDRESS <u>Rt. # 1 10-2</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>GALLOWAY</u> Last | | | | 4. DATE OF DEATH Month <u>NOV.</u> Day <u>6</u> Year <u>1966</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 13 1884</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Brownlie</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>William Bryce Galloway</u> Address <u>Dickerson, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>several years, 19</u> to <u>Nov 6</u> , 19 <u>66</u> , that (I) was lost saw the deceased alive on <u>Oct 26</u> 19 <u>66</u> , and that death occurred at <u>5:58</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>James W. Egan</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS <u>5413 Cedar Lane, Bethesda.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| <u>Burial</u> | | <u>11-8-66</u> | | <u>Mt. Olivet</u> | | <u>Fredrick, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Salamone Funeral Home</u> | | | | ADDRESS <u>Fredrick, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 9 1966</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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UNITED STATES

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10-10-50/2 K/

FROM: JAMES H. HARRIS, JR.
TO: KODAK

URGENT

10-10-50

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-50 BY 1045
1045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15842

15845

| | | | |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| c. LENGTH OF STAY IN 1b <u>7 Hrs.</u> | | d. STREET ADDRESS <u>8811 Colesville Road</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>GATKER</u> Last <u>GATKER</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1966</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-17-00</u> |
| 9. AGE (In years lost birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paint Manufacturer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Mordecai Gatker</u> | | 14. MOTHER'S MAIDEN NAME <u>Bayla Bookman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Stephen L. Pasternak</u> | | Address <u>11608 Lockwd. Dr., Sil. Sp., Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Ghroma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>1 week</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>11 mo.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>66</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>11/30/66</u> , and that death occurred at <u>5:30</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jay N. Shapiro</u> | | 22b. DATE SIGNED <u>11/30/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Jay N. Shapiro</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE THEREOF <u>12/1/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Falls Ch., Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>3501-14th St., N.W. Wash. D.C.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>DEC 1 1966</u> | | | |

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[Faint, illegible handwriting on lined paper, possibly a ledger or notebook page. The text is mirrored across the page, suggesting bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--|--|--|--|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>14 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> 15.1 d. STREET ADDRESS <u>3333 University Blvd. W</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Isabelle NMN GERSTEN FELD</u> First Middle Last | | | 4. DATE OF DEATH <u>November 11</u> 19 <u>66</u> Month Day Year | | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 13, 1916</u> 9. AGE (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswn.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>Sam Weiss</u> 14. MOTHER'S MARDEN NAME <u>Blanche</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>—</u> | | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>Hospital Record.</u> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>amyotrophic lateral sclerosis</u> 3501 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19</u> , 19 <u>64</u> , to <u>Nov 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 10</u> 19 <u>66</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Boris Rabkin</u> | | | | | 22b. DATE SIGNED <u>10/11/66</u> | | 22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN M.D.</u> 22d. ADDRESS <u>1019 University Blvd. East</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 23b. DATE THEREOF <u>11-13-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u> | | 23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH, VA</u> | | |
| 24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> | | | | | 25a. REC'D BY REGISTRAR <u>4217-9-11-66</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

MEDICAL CERTIFICATION

15248

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NO. 1 15248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15844

15847

| | | | | | | | |
|---|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | c. LENGTH OF STAY IN 1b 3 weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 151 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | | | d. STREET ADDRESS 11009 Madison Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Donald F. Gindele | | | | 4. DATE OF DEATH Month Day Year 11- 5 1966 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-7-02 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer - Electrical | | 10b. KIND OF BUSINESS OR INDUSTRY Reg. Express Agency | |
| 11. BIRTHPLACE (County & State, or foreign country) Cincinnati, Ohio | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Herman Gindele | | | | 14. MOTHER'S MAIDEN NAME Bertha Fulton | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Leone Gindele, (same as #2) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Lobular Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bacteremia - Hematuria DUE TO (c) Generalized Hodgkins Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 2 weeks 1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 10, 1966 to Nov 5, 1966 , that (I) (we) last saw the deceased alive on Nov 5, 1966 , and that death occurred at 2:15 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Francis X. Richardson | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/6/66 | |
| 22c. PHYSICIAN'S NAME (Type) FRANCIS X. RICHARDSON | | | | 22d. ADDRESS 11412 VIER'S MILL RD. WHEATON, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 8, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington Virginia | |
| 24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St NW Wash. DC | | | | 25a. REC'D BY REGISTRAR DATE NOV 10 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

15617

BIRTH OF BIRTH

15617

Maryland

Maryland

Maryland

Washington

Silver Spring

11000 Madison Street

Holy Cross Hospital

Gladys

P.

Donald

11-7-02

XX

White

Male

Maryland

Maryland

Elizabeth Johnson

Elizabeth Johnson

Elizabeth Johnson

Maryland

Maryland

Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G38- 12/1/66 mh

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b Washington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 637 Dahlia St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Joanne Last Gnat 4. DATE OF DEATH Month November Day 24 Year 19 66 | | 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 11-24-66 9. AGE (In years last birthday) yrs. 5 10. UNDER 1 YEAR Months 5 Days 35 11. UNDER 24 HRS. Hours 5 Min. 35 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY —p | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas James Gnat | | 14. MOTHER'S MAIDEN NAME Katherine Mary Stanczyk | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Father | | Address same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral subarachnoid hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Associated with marked decrease in platelets DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from 11/24/66 , 19____, to 11/24/66 , 19____, that (I) (we) last saw the deceased alive on 11/24/66 , 19____, and that death occurred at 3:10 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Robert Krichmar</i> M.D. | | 22b. DATE SIGNED NOV 28 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Robert Krichmar, M.D. | | 22d. ADDRESS 7733 Alaska Ave. N.W. Washington D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 26 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | 23d. LOCATION (City or Town) (County) (State) German Hill Road Md | |
| 24. FUNERAL DIRECTOR The Dippel Bros Inc 1800 E Lombard Street | | 25a. REC'D BY REGISTRAR NOV 28 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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Abstract

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Abstracts of the 1998 Annual Meeting of the American Society of Human Genetics, 1998, Denver, Colorado, November 1-5.

Thomas James Gray

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15846 | | | | CERTIFICATE OF DEATH | | | 15849 | | |
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | c. LENGTH OF STAY IN 1b <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> <u>15.1</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hospital</u> | | | | | d. STREET ADDRESS <u>3516 SHEPHERD ST.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD LINWOOD GODFREY</u> | | | | | 4. DATE OF DEATH Month Day Year <u>Nov 22 1966</u> | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 17 1896</u> | | 9. AGE (In years last birthday) <u>70</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>JAMES L. Godfrey</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>LAURA Champion</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1ST WAR</u> | | | 16. SOCIAL SECURITY NO. <u>216-44-4130</u> | | 17. INFORMANT Address <u>DOROTHY GODFREY - WIFE - SAME</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DS</u> (c) <u>5 YEARS</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>to death 1/22, 1966</u> , that (I) (we) last saw the deceased alive on <u>November 19 66</u> , and that death occurred at <u>3:30 P.M.</u> from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Richard B. Perry</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11-22-66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>RICHARD B. PERRY MD</u> | | | | | 22d. ADDRESS <u>2001 EYE ST NW. WASH DC</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-28-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> | | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>NOV 30 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 15847 | | 158511 | |
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 11-1-1966 - 11-12-1966 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTWOOD RETIREMENT HOME 5101 RIDGEFIELD ROAD 20016 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LINDEN HILL TOWERS d. STREET ADDRESS 5400 ROCKS HILL ROAD - BETHESDA e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) KING First P. GOGGINS Middle P. GOGGINS Last | | 4. DATE OF DEATH 11 - 12 19 66 Month Day Year | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-19-1901 9. AGE (in years last birthday) 65 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST | | 10b. KIND OF BUSINESS OR INDUSTRY PRIVATE | |
| 11. BIRTHPLACE (County & State, or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES A. GOGGINS | | 14. MOTHER'S MAIDEN NAME JOHANNA KING | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT JOHN F. GOGGINS (SON) | | Address 7624 DEW WOOD DR ROCKVILLE, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor pulmonale (c) Emphysema | | INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept , 1965, to Nov 12 , 1966, that (I) (we) last saw the deceased alive on Nov 5 , 1966, and that death occurred at 11 A M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE J.E. FITZGERALD | | 22b. DATE SIGNED 11/12/66 | |
| 22c. PHYSICIAN'S NAME (Type) J.E. FITZGERALD | | 22d. ADDRESS 3750 Reservoir Rd N.W. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 11/13/66 | 23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY | 23d. LOCATION (City, town or county) (State) FLINT, MICHIGAN |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO. SILVER SPRING, MD | | 25. REC'D BY REGISTRAR NOV 14 1966 | |
| 25a. ADDRESS 8655 GA. AVE. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

15854

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CENTRAL BANK OF AMERICA

[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15848

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|--|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| c. LENGTH OF STAY IN ID <u>P.O.A.</u> | | d. STREET ADDRESS <u>7401 New Hampshire Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Univ. San. & Hosp.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>PHILIP</u> First <u>GOLDBERG</u> Middle Last | | 4. DATE OF DEATH <u>Oct. 8</u> 19 <u>66</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/21/11</u> 9. AGE (in years last birthday) <u>55</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rate Off. So. Railway.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William Goldberg</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Gross</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWII</u> | | 16. SOCIAL SECURITY NO. <u>Beltsville, Md.</u> | |
| 17. INFORMANT <u>Fred Goldberg</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> (c) <u>4201</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>Nov. 8, 1966</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | DEPUTY MEDICAL EXAMINER <u>Wheaton</u> Address (Street, city, town, or county) <u>Oct. 8, 1966</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 23b. DATE THEREOF <u>11/10/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Kind David Mem. Gard. Cem. Falls Ch., Va.</u> | 23d. LOCATION (City, town or county) (State) |
| 24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u> | | ADDRESS <u>3501-14th St., N.W. Wash. D.C.</u> | |
| 25a. REC'D BY REGISTRAR <u>Nov 10 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Medical Examiner's Office
Examined by [Signature]
Cleared by [Signature]

| <div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>15849</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15852</p> </div> </div> | | | | | | | | | | | | | |
|--|--|---------------------------|-------------------------------------|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | | c. LENGTH OF STAY IN 1b <u>17 HRS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HATTESVILLE</u> | | | | 16-2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSP.</u> | | | | | | d. STREET ADDRESS <u>6516 20th Ave.; GREEN MEADOWS</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Gordon</u> | | | First Middle Last <u>A. Goodwin</u> | | | 4. DATE OF DEATH <u>11 7 1966</u> | | | Month Day Year | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 12 1904</u> | | 9. AGE (In years last birthday) <u>62 yrs.</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Regional corp.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>W.C.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | | |
| 13. FATHER'S NAME <u>QPS Goodwin</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>unk</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>243 07 7109</u> | | 17. INFORMANT <u>Sally Goodwin</u> | | | Address <u># 2</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchogenic carcinoma (right upper lobe)</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January 1963</u> to <u>11-7, 1966</u> that (I) (we) last saw the deceased alive on <u>11-6-1966</u> and that death occurred at <u>5:22</u> M, from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | | | 22b. DATE SIGNED <u>11-7-66</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>JASON GELBER, M.D.</u> | | | | | | 22d. ADDRESS <u>800 PEARSHING DRIVE SILVER SPRING, MD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>Nov. 10, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Hopewood</u> | | 23d. LOCATION (City, town or county) (State) <u>Durham N.C.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Frank Henderson</u> | | | | | | 25a. REC'D BY REGISTRAR <u>3605 14th St NW</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |
| | | | | | | DATE <u>NOV 10 1966</u> | | | | | | | |

15452

15452

Arteriosclerotic heart disease
Congestive heart failure

Chronic bronchitis (left heart failure)

James H. [Signature]
11-7-66
11-7-66
Box 6000
Sick 2000

NOV 10 1966

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15850

CERTIFICATE OF DEATH

15853

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, | | c. LENGTH OF STAY IN lb DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. 15.1 | |
| 3. NAME OF DECEASED (Type or print) Alice Gordon | | 4. DATE OF DEATH Month November Day 13 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH unknown |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR Months 13 Days 19 Hours 66 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jacob Schreiber | | 14. MOTHER'S MAIDEN NAME unavailable | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Son, Address Jacob Gordon 1701 Eastwest Hwy. S.S., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from July, 1965 , to 11-13, 1966 that (I) (we) last saw the deceased alive on 11-8, 1966 and that death occurred at DOA M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Stanley M. Silverberg M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) STANLEY M. SILVERBERG | | 22d. ADDRESS 5201 CONN AVE NW | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11-15-66 | 23c. NAME OF CEMETERY OR CREMATORY Ohev Sholom-Talmud Torah | 23d. LOCATION (City or Town) (County) (State) Washington, DC |
| 24. FUNERAL DIRECTOR Bernard Danzansky and Sons Address Washington DC | | 25a. REC'D BY REGISTRAR NOV 17 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

99
cc
Reap
BP - Cleared by Dr.

15850

15851

| | | | | | | | | | |
|-----------------|--|------------------|--|-----------------|--|-----------------|--|-------------------|--|
| Name | | Address | | City | | State | | Zip | |
| John Doe | | 123 Main St | | New York | | NY | | 10001 | |
| Age | | Sex | | Race | | Religion | | Marital Status | |
| 35 | | Male | | White | | Protestant | | Married | |
| Education | | Occupation | | Income | | Assets | | Liabilities | |
| High School | | Teacher | | \$15,000 | | \$50,000 | | \$20,000 | |
| Social Security | | Health Insurance | | Life Insurance | | Auto Insurance | | Home Insurance | |
| 123-456789 | | ABC Insurance Co | | XYZ Life Ins Co | | DEF Auto Ins Co | | GHI Home Ins Co | |
| Signature | | Date | | Witness | | Notary | | Remarks | |
| John Doe | | 10/1/70 | | Jane Doe | | John Smith | | All in good order | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15851

CERTIFICATE OF DEATH

15854

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|--|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D C b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | c. LENGTH OF STAY IN 1b Washington | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home | | | | d. STREET ADDRESS 4100. W. st N W | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Josephine D. Grabill | | | | 4. DATE OF DEATH Month 11. Day 22. Year 19 66 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5.6.1872 | 9. AGE (In years last birthday) 94 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt Ret | | 10b. KIND OF BUSINESS OR INDUSTRY Civil Ser | | 11. BIRTHPLACE (County & State, or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Samuel Dunham | | | | 14. MOTHER'S MAIDEN NAME Hannah Dunham | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Elta F. Grabill 3051 Idaho ave N W | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchopneumonia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myelocytic Leukemia DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April , 19 66 , to 11/22/66 , 19 66 , that (I) (we) last saw the deceased alive on 11/22/66 19 66 , and that death occurred at 11:00 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Henry C. Scruggs MD | | 22b. DATE SIGNED 11/22/66 | | 22c. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS MD | | 22d. ADDRESS 5413 Cedar Lane Bethesda Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 11.23.66 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION (City or Town) (County) (State) Washington D C | |
| 24. FUNERAL DIRECTOR ADDRESS Lee Funeral Home 300.4th st N E Wash | | | | 25. REC'D BY REGISTRAR NOV 23 1966 | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | |

12324

UNITED STATES

12324

MONTGOMERY COUNTY
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15852

CERTIFICATE OF DEATH

15855

| | | | | | | | | | | | | | |
|--|--|---|---|--|---|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 1b <u>18 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4704 N. Chelsea Lane, 15.1</u> d. STREET ADDRESS <u>Bethesda, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>HAROLD</u> First <u>NATHAN</u> Middle <u>GRAVES</u> Last | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>19 66</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 22, 1887</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Govt.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>JOSHUA GRAVES</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>ROSE PERRY</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>532-26-5974</u> | | 17. INFORMANT Address <u>Corinne T. Graves 4704 N. Chelsea La.</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> <u>331X</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>yes</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work _____ of work _____ | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>17 Nov. 1966</u> that (I) (we) last saw the deceased alive on <u>2 Nov. 1966</u> and that death occurred at <u>6:30</u> M, from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Horace W. Bernton</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/17/66</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>HORACE W. BERNTON</u> | | | | | | 22d. ADDRESS <u>4743 Bradley Blvd., Chevy Chase, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | | 23b. DATE THEREOF <u>11-21-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>PARKDAWN CEMETERY</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE, MARYLAND</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u> ADDRESS <u>BETHESDA, MD.</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>NOV 23 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15853

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15856

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN 1b 3 hours | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last GUSTWICK | | 4. DATE OF DEATH Month November Day 26 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10 July 1928 |
| 9. AGE (In years lost birthday) yrs. 38 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | |
| 11. BIRTHPLACE (State or foreign country) GREATLAKES, ILL | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert Lloyd STEVENSON | | 14. MOTHER'S MAIDEN NAME Winnie COLE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Michael Steven GUSTWICK | | Address RT. 1, BOX 145C LEXINGTON PARK, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation, inspiration of bone particle DUE TO (b) Multiple face and chest injuries from auto accident DUE TO (c) 9 1/2 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 5 mins | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:30am p.m. NOV 26 1966 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RT 232 | | 20f. (City or town) (County) (State) LEXINGTON PARK, MD. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John G. Ball | | 22. DATE SIGNED 11-27-66 | |
| EXAMINER'S NAME (Type) John G. Ball | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 2, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Taloga Cemetery | | 23d. LOCATION (City or Town) (County) (State) Taloga, Oklahoma | |
| 24. FUNERAL DIRECTOR Mattingly Funeral Home, Leonardtown, Md. | | 25a. REC'D BY REGISTRAR DATE NOV 29 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

15858

15858

1. The first of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the market.

2. The second of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the non-market sector.

3. The third of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the government sector.

4. The fourth of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the foreign sector.

5. The fifth of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the non-market sector.

6. The sixth of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the government sector.

7. The seventh of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the foreign sector.

8. The eighth of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the non-market sector.

9. The ninth of the two main groups of the population is the group of the population which is engaged in the production of goods and services for the government sector.

CERTIFICATE OF DEATH

15854

15857

| | | | |
|---|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | c. LENGTH OF STAY IN 1b <u>15.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u> | | d. STREET ADDRESS <u>735 SILVER AVE. # 106</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MANUEL BUTIERREZ-MIGOYA</u> | | 4. DATE OF DEATH Month Day Year <u>11 / 14 / 19 66</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/13/34</u> |
| 9. AGE (In years last birthday) <u>32</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Spain</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Cuba</u> | |
| 13. FATHER'S NAME <u>Jose Gutierrez</u> | | 14. MOTHER'S MAIDEN NAME <u>Amalia Migoya</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Manuel A. Gutierrez, Jr.</u> | | Address <u>641 Sligo Ave. Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5271 Broncho pneumonia.</u> DUE TO (b) <u>Pulmonary emphysema</u> DUE TO (c) <u>many years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>11/9</u> , 19 <u>66</u> , to <u>11/14</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>11/13</u> , 19 <u>66</u> , and that death occurred at <u>2:5 P.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James R. Coleman M.D.</u> | | 22b. DATE SIGNED <u>11/14/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN M.D.</u> | | 22d. ADDRESS <u>9241 COLUMBIA BLVD. SILVER SPRING, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov 17, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Sat. of Heaven</u> | | 23d. LOCATION (City or town) (County) (State) <u>Wheaton, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers</u> | | 25a. REC'D BY REGISTRAR <u>NOV 17 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>James R. Coleman</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

66221

382

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 15855 | | | | | | 15858 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY <u>MONTGOMERY</u> | | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | c. LENGTH OF STAY IN 1b <u>ONE DAY</u> | | | d. STREET ADDRESS <u>12401 BRAXFIELD CT. APT 12</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>HELEN E. HAGEAGE</u> | | | 4. DATE OF DEATH <u>11 - 12 19 66</u> | | | 5. SEX <u>F</u> | | | 6. COLOR OR RACE <u>W</u> | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | | 8. DATE OF BIRTH <u>7-18-63</u> | | | 9. AGE (In years last birthday) <u>3</u> yrs. | | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>GEORGE J. HAGEAGE Jr</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Juliet Puryear</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u> </u> | | | 17. INFORMANT <u>Dr. George J. Hageage, Jr.</u> | | | Address <u>(above)</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC MEMORABLE</u> <u>3255</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>dehydration cardiac</u> DUE TO (c) <u>Tay Sachs Disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 1/2 yrs</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Hypertension</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | | 20f. (City or town) (County) (State) <u> </u> | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-10</u> , 19 <u>66</u> , to <u>11/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> 19 <u>66</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Charles C. Myler</u> | | | | | | 22b. DATE SIGNED <u> </u> | | | 22c. PHYSICIAN'S NAME (Type) <u> </u> | | |
| 22d. ADDRESS <u> </u> | | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22f. ADDRESS <u> </u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>11/14/66</u> | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u> | | | 23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u> | | |
| 24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u> | | | | | | 24a. REC'D BY REGISTRAR <u> </u> | | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |
| 24c. ADDRESS <u>Mt. Rainier, Maryland</u> | | | | | | 24d. DATE <u>NOV 15 1966</u> | | | 24e. REGISTRAR'S SIGNATURE <u> </u> | | |

12222

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DEPARTMENT OF HEALTH

John W. Mason, Jr.

John W. Mason, Jr.

John W. Mason, Jr.

John W. Mason, Jr.

John W. Mason, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15856

CERTIFICATE OF DEATH

15859

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 15-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7016 Poplar Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle L. Last HALLMAN. | | 4. DATE OF DEATH Month Nov. Day 16 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/5/16 |
| 9. AGE (In years last birthday) 50 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Customer Service Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Communications | |
| 11. BIRTHPLACE (County & State, or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry L. Hallman, Sr. | | 14. MOTHER'S MAIDEN NAME Ellie Turner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 254 684 1234 | |
| 17. INFORMANT Mrs. Terry L. Hallman (same as #2) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Convulsions due to chronic Brain Syndrome. | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs. years. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from Nov. 15, 1966 , to Nov 15, 1966 , that (1) (we) last saw the deceased alive on Nov. 15, 1966 , and that death occurred at 4:04 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE James R. Coleman M.D. | | 22b. DATE SIGNED Nov. 16, 1966. | |
| 22c. PHYSICIAN'S NAME (Type) James R. Coleman, M.D. | | 22d. ADDRESS 9241 Columbia Blvd., Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Nov. 19, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State) Pt. Dev. Co. Maryland |
| 24. FUNERAL DIRECTOR William Walters Washington, D.C. | | 25. REC'D BY REGISTRAR NOV 17 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

CLEARED BY DR. REAP

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MINISTRE OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15857

CERTIFICATE OF DEATH

15860

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boolesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boolesville</u> 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Chester Benjamin Harper</u> | | 4. DATE OF DEATH <u>November 2</u> 19 <u>66</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>June 1, 1895</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery</u> |
| 13. FATHER'S NAME <u>George C. Harper</u> | | 14. MOTHER'S MAIDEN NAME <u>Rose Lee</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Mrs. Elsie Capland Boolesville</u> Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Bronchial, Bilateral,</u> DUE TO (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Carcinoma of Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 months</u> <u>1 year plus</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis, Generalized</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>56</u> , to <u>2 Nov</u> , 19 <u>66</u> , that he <u>she</u> last saw the deceased alive on <u>2 Nov.</u> 19 <u>66</u> , and that death occurred at <u>10:15 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Gordon Murdoch Smith</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>2 Nov. '66</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>Gordon Murdoch Smith, M.D.</u> | | 22d. ADDRESS <u>Barnesville, Maryland.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>11/6/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Boolesville Montg Md.</u> |
| 24. FUNERAL DIRECTOR <u>Robert L. Suowden Rockville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 10 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15858

CERTIFICATE OF DEATH

15861

| | | | |
|---|------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| c. LENGTH OF STAY IN 1b <u>3 wks. 2 days</u> | | d. STREET ADDRESS <u>12003 Colin Road</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C</u> Last <u>Harrison</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/15/28</u> |
| 9. AGE (In years last birthday) yrs. <u>38</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Bud. Hodson</u> | | 14. MOTHER'S MARDEN NAME <u>Nesie Jenkins</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>227-28-7400</u> | |
| 17. INFORMANT <u>Albert Harrison</u> Address <u>same as above</u> | | (Husband) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621 METASTATIC CARCINOMA</u> DUE TO (b) <u>CARCINOMA OF BRONCHUS</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>AT LEAST 8 MONTHS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1964</u> , 19 <u>64</u> , to <u>NOV 4th</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>NOV 4th</u> , 19 <u>66</u> , and that death occurred at <u>6:40</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Michael Madeloff</u> | | 22b. DATE SIGNED <u>11-5-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MICHAEL MADELOFF</u> | | 22d. ADDRESS <u>10620 G.A. AVE. SILVER SPRING MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/7/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>Mt. Rainier, Maryland</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>NOV 9 1966</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

15859

CERTIFICATE OF DEATH

15862

| | | | |
|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | c. LENGTH OF STAY IN 1b <u>2 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | d. STREET ADDRESS <u>525 Thayer Ave</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>G.</u> Last <u>FRASSE</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/19/00</u> |
| 9. AGE (In years last birthday) <u>66 yrs.</u> | | IF UNDER 1 YEAR Months <u>23</u> Days <u>19</u> Hours <u>66</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Albany, New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John B. Gervais</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Bastian</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u> <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>Yes</u> | |
| 17. INFORMANT <u>Florence Gervais</u> | | Address <u>3143 Tennyson St., N. W. Washington, D. C.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1962</u> to <u>November 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>November 19, 1966</u> , and that death occurred at <u>7:30 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Ralph F. Fatten</u> | | 22b. DATE SIGNED <u>11/23/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>RALPH F. FATTEN</u> | | 22d. ADDRESS <u>1407 Woods Rd. Rockville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 29, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 1 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

2923

1582

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 15860 | | | | | 15863 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Jacksonville | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville | | | | | | | | | |
| c. LENGTH OF STAY IN 1b 96 Days | | | | | d. STREET ADDRESS 3960 Via de la Reina | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland | | | | | | | | | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Ernest | | | First Hawtin | | | Middle Heatherbell | | | Last | | | | | |
| 4. DATE OF DEATH November 13 1966 | | | Month November | | | Day 13 | | | Year 1966 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1903 | | 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months 13 Days 19 Hours 66 Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Manager | | | | 10b. KIND OF BUSINESS OR INDUSTRY Quaker Oats Co. | | | | 11. BIRTHPLACE (County & State, or foreign country) Canada | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME William Heatherbell | | | | | 14. MOTHER'S MAIDEN NAME Mary Hawthaine | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. 223-09-8487 | | | | | 17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Pheochromocytoma 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 years | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Urinary Tract Infection | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 August 1966 , to 13 November 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 13 November 1966 , and that death occurred at 8:25M , from the causes and on the date stated above. | | | | | | | | | | 22b. DATE SIGNED | | | | |
| 22a. SIGNATURE Karl Engelman | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. PHYSICIAN'S NAME (Type) Karl Engelman, M.D. | | | | | | | | |
| 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | 23b. DATE THEREOF 11-15-66 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) (State) Jacksonville, Florida | | | | | | |
| 24. FUNERAL DIRECTOR Frazier's - Washington, D. C. | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR NOV 17 1966 | | | | |
| | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | |

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CERTIFICATE OF DEATH

15864

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|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>2 mos 14 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | d. STREET ADDRESS <u>11321 Collegeview Drive</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Vernice Heckathorn</u> | | 4. DATE OF DEATH Month Day Year <u>Nov 28 19 66</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/20/41</u> |
| 9. AGE (In years last birthday) <u>25</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>College Student</u> | | 12. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>John H. Heckathorn</u> | | 14. MOTHER'S MAIDEN NAME <u>Onda Gorton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-44-3384</u> | |
| 17. INFORMANT <u>Father</u> | | Address <u>Same as Item 2.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral lobular pneumonia</u> DUE TO (b) <u>Multiple sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> , 19 <u>66</u> , to <u>11/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>66</u> , and that death occurred at <u>9:47</u> A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Francis X Richardson</u> | | 22b. DATE SIGNED <u>11/28/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Francis X Richardson</u> | | 22d. ADDRESS <u>1142 Vices Mill Rd Wheaton Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>12-1-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda Md</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 2 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|-------------------------------------|--|---------------------------------|--|
| Name: [illegible] | | Date: [illegible] | |
| Address: [illegible] | | City: [illegible] | |
| State: [illegible] | | Zip: [illegible] | |
| Occupation: [illegible] | | Education: [illegible] | |
| Marital Status: [illegible] | | Number of Children: [illegible] | |
| Religion: [illegible] | | Political Party: [illegible] | |
| Social Security Number: [illegible] | | Mailing Address: [illegible] | |
| Phone Number: [illegible] | | Telex Number: [illegible] | |
| Birth Date: [illegible] | | Birth Place: [illegible] | |
| Death Date: [illegible] | | Death Place: [illegible] | |
| Cause of Death: [illegible] | | Burial Place: [illegible] | |
| Funeral Home: [illegible] | | Cemetery: [illegible] | |
| Next of Kin: [illegible] | | Relationship: [illegible] | |
| Signature: [illegible] | | Witness: [illegible] | |
| Notary Public: [illegible] | | Commission Expires: [illegible] | |

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STP

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15862

15865

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>27 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u> | | d. STREET ADDRESS <u>5500 Uppingham St</u> 1511 | |
| 3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Emma</u> Last <u>HEINTZ</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-16-78</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>William Wagner</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Rothwell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>579-10-1984</u> | |
| 17. INFORMANT <u>Hospital Record</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sacro intestinal hemorrhage</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>5 days</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>66</u> , to <u>4/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/16</u> , 19 <u>66</u> , and that death occurred at <u>2:15 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u> | | 22d. ADDRESS <u>7105 RIGGS RD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov 29/1966</u> | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR <u>Abraham's Funeral Home, Gaithersburg, Md</u> | | 25a. REC'D BY REGISTRAR <u>NOV 22 1966</u> | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

73851

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--------------------------------------|---|---|---|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 15863 | | | | | 15866 | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Asbury Methodist Home for the Aged, Inc. | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Helen | | First Cassell | | Middle Hilbert | | Last Hilbert | | 4. DATE OF DEATH Month Nov Day 20 Year 1966 | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 10, 1884 | | 9. AGE (in years last birthday) 82 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Woodberry, Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John Samuel Cassell | | | | | 14. MOTHER'S MAIDEN NAME Louisa N. Smith | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. 213-10-3913 | | 17. INFORMANT Asbury Methodist Home, Gaithersburg, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon with metastases 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 yrs | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/25/63 19, to 11/20/66 19, that (I) (we) last saw the deceased alive on 11/29/66 19, and that death occurred at 330 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Henry C. Scruggs MD. | | | | | 22b. DATE SIGNED 11/20/66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) 5413 Cedar Lane Bethesda Md | | | | | 22d. ADDRESS Henry C. Scruggs MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/22/66 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | | 23d. LOCATION (City, town or county) (State) Baltimore Md | | |
| 24. FUNERAL DIRECTOR Elsie Mae Nabb | | | | | ADDRESS 301 Frederick Rd Baltimore 28 Md | | 25a. REC'D BY REGISTRAR NOV 23 1966 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge |

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Leon Gray

2000-01-01

Copyright

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22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>16-3</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>7011 17th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>BOHN</u> Last <u>HILL</u> | | | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1966</u> | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>OCT 23, 1897</u> | | 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>FRANK HILL</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>MARY BOHN</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>160-14-5089</u> | | 17. INFORMANT <u>Richard Hill</u> Address <u>7011-17th Ave Hyattsville Md</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Two years +</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>11-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> 19 <u>66</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Shirley Nelson</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11-3-66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/6/1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Church</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Arthur Walters</u> | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |
| 25c. ADDRESS <u>254 Capitol St. NW</u> | | | | | | DATE <u>NOV 7 1966</u> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|------------------|--|---|--|--|--|---|--|------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 15865 | | | | | | 15868 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | |
| a. COUNTY Montgomery | | | | | | a. STATE Maryland | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Damascus | | | | | | b. COUNTY Montgomery | | | | | |
| c. LENGTH OF STAY IN 1b Years | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Damascus | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1, Gaithersburg | | | | | | d. STREET ADDRESS Route # 1, Gaithersburg | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | |
| First Middle Last Mary E. Hiltner | | | | | | Month Day Year November 12 19 66 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR | |
| Female | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | February 1, 1890 | | 76 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | | 11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | | | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Marion Strailman | | | | | | Mae Gosnell | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | | | | |
| No | | | | | | 220 16 2160 | | | | | |
| 17. INFORMANT | | | | | | Address | | | | | |
| Mrs. Hubert S. Yinger, Jr. | | | | | | Rt. # 1, Gaithersburg Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 10 years | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/6 to 11/12, 1966, that (I) saw the deceased alive on 11/7, 1966, and that death occurred at 1:30 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE James P. Kerr 22c. PHYSICIAN'S NAME (Type) JAMES P. KERR | | | | | | 22b. DATE 11/12/66 22d. ADDRESS DAMASCUS, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF Nov. 14, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town or county) (State) Frederick, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland | | | | | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge DATE NOV 15 1966 | | | | | |

15388

CERTIFICATE OF DEATH

15388

James J. Kern

James J. Kern

James J. Kern

White

15388

James J. Kern

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15866

CERTIFICATE OF DEATH

15869

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. LENGTH OF STAY IN 1b <u>22 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>FRENCH</u> Middle <u>-</u> Last <u>Hobbs</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>1966</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>Oct 12, 1881</u> | | 9. AGE (In years lost birthday) <u>85</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fanner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>M. Franklin Hobbs</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Monthe Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-26-7068</u> | | 17. INFORMANT <u>Mrs. W. F. Hobbs</u> Address <u>Olney, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>20 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>66</u> , to <u>Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 21</u> 19 <u>66</u> , and that death occurred at <u>8:15 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>A. D. Borikant</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/24/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. D. BORIKANT</u> | | | | 22d. ADDRESS <u>Sandy Springs, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-26-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Sunshine Mont. Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Francis H. Barber</u> | | | | 25a. REC'D BY REGISTRAR <u>NOV 28 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

113251

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Witness H. E. Brown, Daytonville, Mo.
Jury Trial 11-26-05
At. Counsel

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Not by Dr. John Ball 2 P.M.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15867

CERTIFICATE OF DEATH

15870

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium | | d. STREET ADDRESS 7207 Maple Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Olive Middle G Last Hough | | 4. DATE OF DEATH Month November Day 11 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH January 23, 1886 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Gilmore | | 14. MOTHER'S MAIDEN NAME Flora Belle Hendricks | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Norman G. Hough, Jr., Same as #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Generalized arteriosclerosis, Cardiac and pulmonary arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis 12/65 & 10/8/66 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from January , 1965, to 11/11 , 1966, that (I) (we) last saw the deceased alive on 11/9 1966, and that death occurred at 1:20 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Edwin P. Parker | | 22b. DATE SIGNED Nov. 11, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Edwin Parker | | 22d. ADDRESS 2015-28th NW - Wash DC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/14/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem | | 23d. LOCATION (City or Town) (County) (State) Bladensburg, Md | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C. | | 25a. REC'D BY REGISTRAR NOV 18 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1283

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CERTIFICATE OF DEATH

15868

15871

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|---|--|--|-------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK-MD</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD 15.1</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & HOSP.</u> | | | | d. STREET ADDRESS <u>1028 Quebec TERRACE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Josephine</u> Last <u>HOUSLEY</u> | | | | 4. DATE OF DEATH <u>November 14</u> 19 <u>66</u> Month Day Year | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>6-7-13</u> | |
| 9. AGE (In years last birthday) <u>53</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE DETECTIVE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL-DEPT-STORE</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | | | | 13. FATHER'S NAME <u>ALEX HAYNOS</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>ANNA</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. <u>175-22-0981</u> | | | | 17. INFORMANT <u>Mrs. Douglas R. Chester</u> Address <u>1028 Quebec Ter.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4201</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 d.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Arterial Hypertension, (old) thrombophle</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 14, 1965</u> , to <u>Oct 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 19, 1966</u> , and that death occurred at <u>1028 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Arthur S. Bresler</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>Nov 14, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER, M.D.</u> | | | | 22d. ADDRESS <u>10881 LOCKWOOD DRIVE SILVER SPRING MARYLAND.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 17, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Melrose Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Bridgetown, Penna</u> | |
| 24. FUNERAL DIRECTOR <u>J. Arthur Walter, 254 Carroll St. N.W. Wash D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>NOV 16 1966</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12831

INSTITUTE OF HEALTH

12831

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

Items 18&21 Fill in 187 1-10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

15872

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> | | c. LENGTH OF STAY IN 1b <u>1 week</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>L.</u> Last <u>Hunter</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>19 66</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 16, 1893</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Canada</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John Black</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucinda Young</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO. <u>103-18-4472A</u> | |
| 17. INFORMANT <u>Mrs. Ruth Ausdall</u> | | 17. ADDRESS <u>1725 Cody Dr. Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>Bilateral atelectasis</u> DUE TO (c) <u>Carcinoma of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Belden R. Reap</u> | | 11502 Grandview Ave. Wheaton, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Bayville Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Long Island, New York</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u> | | 24a. REC'D BY REGISTRAR <u>NOV 18 1966</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15870

CERTIFICATE OF DEATH

15873

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | c. LENGTH OF STAY IN 1b 1 1/2 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | | | d. STREET ADDRESS 515 Thayer Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Cora Middle Mary Last Hurley | | | | 4. DATE OF DEATH Month November Day 25 Year 1966 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 6, 1906 | | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - - - | | 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Garland | | | | 14. MOTHER'S MAIDEN NAME Mary Bowls | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - | | 16. SOCIAL SECURITY NO. - - - | | 17. INFORMANT Address Mrs. Coralie A. Geiwitz, Rockville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X CARCINOMA of THE BREAST DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/19 , 19 66 to 11/25 , 19 66 , that (I) (we) last saw the deceased alive on 11/25 , 19 66 , and that death occurred at 9P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard H. Pollen | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/26/66 | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN MD | | | | 22d. ADDRESS 10400 CONNECTICUT AVE KENSINGTON MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-30-1966 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem | | 23d. LOCATION (City or Town) (County) (State) Arlington, Va | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC. | | | | 25a. REC'D BY REGISTRAR DATE DEC 1 1966 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | |

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OFFICE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15871

15874

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) | | c. LENGTH OF STAY IN 1b 7 hrs 30 min | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Louise Middle Snyder Last JAMES | | 4. DATE OF DEATH Month November Day 28 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 15, 1920 |
| 9. AGE (In years last birthday) 45 yrs. | | 10. IF UNDER 1 YEAR Months 45 Days 45 Hours 45 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Dayle Snyder | | 14. MOTHER'S MAIDEN NAME Beatrice Rose | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 337-14-2168 | |
| 17. INFORMANT Arlington | | Address Va. Capt. Jack M. James, 4716 North Dittmar Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningioma Left Temporal Lobe Brain Benign DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 223X | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (it) (this hospital) attended the deceased from Nov. 28 , 1966, to Nov. 28 , 1966, that (it) (we) last saw the deceased alive on Nov. 28 , 1966, and that death occurred at 4:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE P.T. Kirchner | | 22b. DATE SIGNED 29 Nov. 1966 | |
| 22c. PHYSICIAN'S NAME (Type) P.T. Kirchner MD | | 22d. ADDRESS Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/1/1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Dennisville Memorial | | 23d. LOCATION (City or Town) (County) (State) Dennisville, New Jersey | |
| 24. FUNERAL DIRECTOR Arlington Funeral Home 3901 North Fairfax Drive, Arlington, Va. | | 25a. REC'D BY REGISTRAR DATE DEC 2 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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• 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642,

Demetrius, New Jersey

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15872

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15872

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 8 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6309 Orchid Drive | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6309 Orchid Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ANNA JINGO First Middle Last | | 4. DATE OF DEATH Nov. 13, 1966 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 27, 1880 9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Roumania 12. CITIZEN OF WHAT COUNTRY? U. S. |
| 13. FATHER'S NAME George Sumley | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 296-03-4935D 17. INFORMANT Daughter Address Same as Item 2. Mrs. Raymond Kerr | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | INTERVAL BETWEEN ONSET AND DEATH Sudden. years |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Bethesda, Md. | | | |
| ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) JOHN G. BALL | | 22. DATE SIGNED Nov. 14, 1966 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11-16-66 | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | 23d. LOCATION (City, town or county) (State) Rockville, Maryland |
| 24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR NOV 21 1966 DATE 25b. REGISTRAR'S SIGNATURE J Charles Judge | |

15873

15873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15873

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15873

CERTIFICATE OF DEATH

15876

| | | | |
|---|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10231 Carroll Place Carroll Hall Sanitarium | | d. STREET ADDRESS 5350 Nebraska Ave. N.W. | |
| 3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Johnson Last Johnson | | 4. DATE OF DEATH Month Nov Day 4 Year 1966 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8/24/78 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 19 Hours 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Johnson | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-54-7753 | |
| 17. INFORMANT Mrs. Felix M. Halluin same as #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic valvular heart disease DUE TO (c) dissection | | INTERVAL BETWEEN ONSET AND DEATH 15 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 1 19 66 to Nov 4 19 66 that (I) (we) last saw the deceased alive on Nov 1 19 66 and that death occurred at 12:45 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Andrew E. Rudnai | | 22b. DATE SIGNED 11-4-66 | |
| 22c. PHYSICIAN'S NAME (Type) Andrew E. Rudnai | | 22d. ADDRESS 1720 New Arthur Blvd. Wash. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 11/7/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md | |
| 24. FUNERAL DIRECTOR S.H. Hines Co. Wash. D.C. | | 25a. REC'D BY REGISTRAR NOV 7 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

12873

12873

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|----------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 1, 1930 | | New York, N.Y. | |
| Cause of Death | | Manner of Death | | Occupation | | Education | | Religion | |
| Heart Disease | | Natural | | Teacher | | High School | | Catholic | |
| Date of Death | | Place of Death | | Physician | | Hospital | | Burial Place | |
| Jan 15, 1975 | | New York, N.Y. | | Dr. Smith | | St. Mary's | | St. Mary's Cemetery | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Witness | | Signature of Coroner | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Date of Certificate | | Place of Certificate | | Physician | | Hospital | | Burial Place | |
| Jan 15, 1975 | | New York, N.Y. | | Dr. Smith | | St. Mary's | | St. Mary's Cemetery | |

THIS CERTIFICATE IS VALID FOR ALL PURPOSES AND WILL BE ACCEPTED AS SUCH BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES OF AMERICA.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

| MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
|--|----------------------------|---|---------------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> 151 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8709 Susanna Lane</u> | | | | d. STREET ADDRESS <u>8709 Susanna Lane</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jo</u> Middle <u>Bess</u> Last <u>Johnson</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1966</u> | | | | | | | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 9 1946</u> | 9. AGE (In years last birthday) <u>20</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | |
| 13. FATHER'S NAME <u>Kenneth Bradley Johnson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Smart</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot of Abdomen</u> 976X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in upper abdomen with shot gun - 12 gauge</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. - <u>10 PM</u> <u>Nov 20</u> <u>1966</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Cherry Chase - Monte Md.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>John B. Ball</u> | | EXAMINER'S NAME (Type) <u>John G. Ball</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>7938 Old Georgetown Road</u> Address (Street, city, town, or county) | | 22. DATE SIGNED <u>11/20/66</u> <u>Bethesda Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/23/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u> | | | |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> Address <u>1331 Rockville Pike</u> <u>Rockville, Maryland</u> | | | | 25a. REC'D BY REGISTRAR <u>NOV 22 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

15817

15817



15817

From the collection of the
National Archives and Records Administration
15817

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15875

CERTIFICATE OF DEATH

15878

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 45 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashton | | 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Sarah Middle Rebecca Last Johnson | | 4. DATE OF DEATH Month Nov. Day 1 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-3-86 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Isaiah Dent | | 14. MOTHER'S MAIDEN NAME Sarah ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Montgomery General Hospital Olney, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UREMIA DUE TO (c) ARTERIOSCLEROTIC C.V. DISEASE | | INTERVAL BETWEEN ONSET AND DEATH 3-4 WKS+ YRS. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CEREBRAL THROMBOSIS : OBSTRUCTIVE JAUNDICE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 9/14 , 19 66 to Nov 1 , 19 66 , that (1) (we) last saw the deceased alive on 10/31 , 19 66 , and that death occurred at 1:00 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Donald P. Lewis | | 22b. DATE SIGNED 11/1/66 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 11/7/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or town) (County) (State) Arlington VA. | |
| 24. FUNERAL DIRECTOR George R. Brandon | | 25a. REC'D BY REGISTRAR Rockville Md | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE NOV 7 1966 | |

15878

CENTRAL DE MATH

15878

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15876

CERTIFICATE OF DEATH

15879

| | | | |
|--|---------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN lb 32 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d.c. 47-3 | |
| | | d. STREET ADDRESS 5920 14th st NW | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Helen Middle Stewart Last JONES | | 4. DATE OF DEATH Month November Day 18 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan 30, 1894 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months 72 Days 18 Hours 19 Min. 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Chester New York | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Charles B STEWART | | 14. MOTHER'S MAIDEN NAME Mary C VAN KLEECK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT Ernest L. JONES | | Address 5920 14th st NW WASH. D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x CARCINOMA LEFT BREAST with widespread metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 170x DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 18 OCT , 19 66 , to 18 NOV , 19 66 , that (I) (we) last saw the deceased alive on 18 NOV , 19 66 , and that death occurred at 7:25 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Francis D. Keenan Jr.</i> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Francis D. KEENAN Jr. | | 22d. ADDRESS USNH, BETHESDA, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 11/21/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 23d. LOCATION (City or Town) (County) (State) Elizabeth, New Jersey | |
| 24. FUNERAL DIRECTOR S.H. HINES CO. 14th St. N.W., WASH., D.C. | | 25a. REC'D BY REGISTRAR DATE NOV 23 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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C. B. HINES CO. 1000 N. W. 10th St., Wash., D.C.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15880

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsda D.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>11721 Glen Mill Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Justement</u> Middle <u>Tr</u> Last <u>Tr</u> | | 4. DATE OF DEATH <u>11-22</u> Month <u>11</u> Day <u>22</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-19-1929</u> |
| 9. AGE (In years last birthday) <u>37</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Louis</u> | | 14. MOTHER'S MAIDEN NAME <u>Jeannie Eger</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-28-9484</u> | |
| 17. INFORMANT <u>Wife - Beverly W. Same</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>431X</u> IMMEDIATE CAUSE (a) <u>Myocarditis, Acute, Viral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John H. Ball</u> M.D. | | 22. DATE SIGNED <u>11/22/66</u> | |
| EXAMINER'S NAME (Type) <u>John H. Ball</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE THEREOF <u>11-25-1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u> ADDRESS <u>N.W. 130 Wash. DC.</u> | | 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1287

1288

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15878

CERTIFICATE OF DEATH

17396

1. PLACE OF DEATH

a. COUNTY

4900-STRATHMORE AVE, MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

GARRETT PARK

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

MD, Pa.

MAINTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lancaster

d. STREET ADDRESS

430 West Vine St.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

SR. M.

JOAN

KAETZ

4. DATE OF DEATH

Month

Day

Year

11

25

1966

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☒

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Fe

W

WIDOWED ☐ DIVORCED ☐

12/17/1889

77 yrs.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Religious

Lancaster - PA

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

SR. Superior

4900-STRATHMORE AVE, 9th, PR

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

420.1 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO

CORONARY Thrombosis

CORONARY Art. Sclerosis

Atrial Fibrillation

9 hrs

4 hrs

3 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work ☐

Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2/21/66 to 11/25/66 that (I) (we) last saw the deceased alive on 11/24/66 and that death occurred at 8:00 AM from the causes and on the date stated above.

22a. SIGNATURE

Stephen W. Jones MD

M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

11/25/66

22c. PHYSICIAN'S NAME (Type)

Stephen W. Jones MD

22d. ADDRESS

809 Vicks Mill Rd, Rock, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

Burial 11-25-66

11-25-66

MT. OLIVE

Wash D.C.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Thomas B. Haula - 4748-Wisc. Ave NW

DATE JAN 6 1967

Charles Judge

VR A15 (4)
15M 9/60

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26. 2000. 2000. 2000.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP Cleared to medical Examiner

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15879 | | | | | CERTIFICATE OF DEATH | | | 15881 | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Kensington Md. | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Nursing Home | | | | | d. STREET ADDRESS 6206 Kilmer Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Anna M. Kahne | | | | | 4. DATE OF DEATH Month Nov Day 21 Year 1966 | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan 2, 1890 | | 9. AGE (In years last birthday) yrs. 76 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (County & State, or foreign country) Bradford Viriniga | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 13. FATHER'S NAME John Lindsay | | | | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth Keitel | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT George F. Kahne Address Seabrook, Maryland. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH days Years Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident, residuals of | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 , 19 65 , to 21 Nov, 1966 , that (I) (we) last saw the deceased alive on 11 Oct 1966 , and that death occurred at 5:55 AM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Robert T. Kelley | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED 21 Nov 66 | | | |
| 22c. PHYSICIAN'S NAME (Type) Robert T. Kelley | | | 22d. ADDRESS 1302-18th St. NW DC. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 23, 1966 | | 23c. NAME OF CEMETERY OR CREMATOR Ft Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR DATE NOV 23 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

12321

556

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15880

15882

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>17 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>10911 Candlelight Lane</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Alexander</u> First <u>Kefauver</u> Middle <u>Rex</u> Last <u>Kefauver</u> | | 4. DATE OF DEATH <u>11-2</u> Month <u>11</u> Day <u>2</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-26-1880</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jacob Kefauver</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Morrison</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-34 9110 A</u> | |
| 17. INFORMANT <u>Richard A. Lister</u> | | Address <u>Same as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Infarction (right) massive myocardial infarction</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 18, 1966</u> to <u>Nov 2, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 2, 1966</u> , and that death occurred at <u>12 M</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Allen J. O'Neill</u> | | 22b. DATE SIGNED <u>Nov 3, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill, MD</u> | | 22d. ADDRESS <u>8601 Old Georgetown Rd Bethesda Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>11-4-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 26. DATE <u>NOV 10 1966</u> | | 27. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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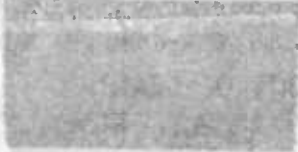
CERTIFICATE OF DEATH

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| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ken 5119 Ave</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>3815-Tedster Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Vernon L.</u> Middle <u>Ke</u> Last <u>Fauver</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1966</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/9/74</u> |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u> Hours <u>0</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harman Ke Fauver</u> | | 14. MOTHER'S MAIDEN NAME <u>Sallie Rortzahn</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Walter Ommundsen</u> | | Address <u>Friend.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA, ARTERIOSCLEROTIC HEART DI</u> DUE TO (b) <u>GENERALIZED ARTERIOXLEROSIS</u> DUE TO (c) <u>YEARS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>66</u> , to <u>11/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>66</u> and that death occurred at <u>5 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Richard H. Pollen</u> | | 22b. DATE SIGNED <u>11/27/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u> | | 22d. ADDRESS <u>10400 CONNECTICUT AVE, KENSINGTON MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/30/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> | | 25. RECEIVED BY REGISTRAR <u>Charles Judge</u> | |
| 25a. ADDRESS <u>1331 Rockville Pike</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>DEC 1 1966</u> | | | |

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[Faint, mostly illegible text and markings on lined paper, possibly bleed-through from the reverse side. Some faint words like "E", "D", "O", "T", "A", "R", "E" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G383 12/14/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaumont, D.C.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood</u> 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>54 Burbank</u> | | d. STREET ADDRESS <u>3811 - Brooks Dr.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>F. FREEMONT ELLIS</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1966</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 14, 1912</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR, US GOV'T. of 7 Aug General</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Erie, Pa</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Erie, Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>J.E. Kelsey</u> | | 14. MOTHER'S MAIDEN NAME <u>Margie Ellis</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Dr. Frances O. Kelsey, Same as #2</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency. Acute.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardio Vascular Disease.</u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/16/66 | |
| | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11/18/66</u> | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) <u>Erie, Penna.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u> | | 25a. REC'D BY REGISTRAR <u>NOV 18 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A15 (4)
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 15883 | | | | | CERTIFICATE OF DEATH | | | | | 15885 | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | c. LENGTH OF STAY IN 1b 31 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15.1 | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring | | | | | d. STREET ADDRESS 400 East Indian Spring Dr. S | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) William Augustine Kemp First Middle Last | | | 4. DATE OF DEATH Nov. 26 1966 Month Day Year | | | | | | | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/9/89 | | 9. AGE (In years last birthday) 33 7/8 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Broker | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | | 11. BIRTHPLACE (County & State, or foreign country) District of Columbia | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME George W. Kemp | | | | 14. MOTHER'S MAIDEN NAME Cecily Wood | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 578-10-0650 | | 17. INFORMANT Phyllis E. Kemp 400 East Indian Spring Dr. Silver Spring, Md. Address | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 10/31 , 19 66 , to 11/26 , 19 66 , that (I) (we) last saw the deceased alive on 11/26 , 19 66 , and that death occurred at 5P M, from causes and on the date stated above. 22a. SIGNATURE Joseph F. Schanno M.D. 22b. DATE SIGNED 11/26/66 22c. PHYSICIAN'S NAME (Type) Joseph F. Schanno 22d. ADDRESS 9218 Wisconsin Ave Bethesda | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 30, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Washington, D. C. | | | | | | | |
| 24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc. | | | | ADDRESS 8434 Georgia Ave. Silver Spring, Md. | | 25a. REC'D BY REGISTRAR DEC 1 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | |

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0-20 21-40 41-60 61-80 81-100 101-120 121-140 141-160 161-180 181-200 201-220 221-240 241-260 261-280 281-300 301-320 321-340 341-360 361-380 381-400 401-420 421-440 441-460 461-480 481-500 501-520 521-540 541-560 561-580 581-600 601-620 621-640 641-660 661-680 681-700 701-720 721-740 741-760 761-780 781-800 801-820 821-840 841-860 861-880 881-900 901-920 921-940 941-960 961-980 981-1000 1001-1020 1021-1040 1041-1060 1061-1080 1081-1100 1101-1120 1121-1140 1141-1160 1161-1180 1181-1200 1201-1220 1221-1240 1241-1260 1261-1280 1281-1300 1301-1320 1321-1340 1341-1360 1361-1380 1381-1400 1401-1420 1421-1440 1441-1460 1461-1480 1481-1500 1501-1520 1521-1540 1541-1560 1561-1580 1581-1600 1601-1620 1621-1640 1641-1660 1661-1680 1681-1700 1701-1720 1721-1740 1741-1760 1761-1780 1781-1800 1801-1820 1821-1840 1841-1860 1861-1880 1881-1900 1901-1920 1921-1940 1941-1960 1961-1980 1981-2000 2001-2020 2021-2040 2041-2060 2061-2080 2081-2100 2101-2120 2121-2140 2141-2160 2161-2180 2181-2200 2201-2220 2221-2240 2241-2260 2261-2280 2281-2300 2301-2320 2321-2340 2341-2360 2361-2380 2381-2400 2401-2420 2421-2440 2441-2460 2461-2480 2481-2500 2501-2520 2521-2540 2541-2560 2561-2580 2581-2600 2601-2620 2621-2640 2641-2660 2661-2680 2681-2700 2701-2720 2721-2740 2741-2760 2761-2780 2781-2800 2801-2820 2821-2840 2841-2860 2861-2880 2881-2900 2901-2920 2921-2940 2941-2960 2961-2980 2981-3000 3001-3020 3021-3040 3041-3060 3061-3080 3081-3100 3101-3120 3121-3140 3141-3160 3161-3180 3181-3200 3201-3220 3221-3240 3241-3260 3261-3280 3281-3300 3301-3320 3321-3340 3341-3360 3361-3380 3381-3400 3401-3420 3421-3440 3441-3460 3461-3480 3481-3500 3501-3520 3521-3540 3541-3560 3561-3580 3581-3600 3601-3620 3621-3640 3641-3660 3661-3680 3681-3700 3701-3720 3721-3740 3741-3760 3761-3780 3781-3800 3801-3820 3821-3840 3841-3860 3861-3880 3881-3900 3901-3920 3921-3940 3941-3960 3961-3980 3981-4000 4001-4020 4021-4040 4041-4060 4061-4080 4081-4100 4101-4120 4121-4140 4141-4160 4161-4180 4181-4200 4201-4220 4221-4240 4241-4260 4261-4280 4281-4300 4301-4320 4321-4340 4341-4360 4361-4380 4381-4400 4401-4420 4421-4440 4441-4460 4461-4480 4481-4500 4501-4520 4521-4540 4541-4560 4561-4580 4581-4600 4601-4620 4621-4640 4641-4660 4661-4680 4681-4700 4701-4720 4721-4740 4741-4760 4761-4780 4781-4800 4801-4820 4821-4840 4841-4860 4861-4880 4881-4900 4901-4920 4921-4940 4941-4960 4961-4980 4981-5000 5001-5020 5021-5040 5041-5060 5061-5080 5081-5100 5101-5120 5121-5140 5141-5160 5161-5180 5181-5200 5201-5220 5221-5240 5241-5260 5261-5280 5281-5300 5301-5320 5321-5340 5341-5360 5361-5380 5381-5400 5401-5420 5421-5440 5441-5460 5461-5480 5481-5500 5501-5520 5521-5540 5541-5560 5561-5580 5581-5600 5601-5620 5621-5640 5641-5660 5661-5680 5681-5700 5701-5720 5721-5740 5741-5760 5761-5780 5781-5800 5801-5820 5821-5840 5841-5860 5861-5880 5881-5900 5901-5920 5921-5940 5941-5960 5961-5980 5981-6000 6001-6020 6021-6040 6041-6060 6061-6080 6081-6100 6101-6120 6121-6140 6141-6160 6161-6180 6181-6200 6201-6220 6221-6240 6241-6260 6261-6280 6281-6300 6301-6320 6321-6340 6341-6360 6361-6380 6381-6400 6401-6420 6421-6440 6441-6460 6461-6480 6481-6500 6501-6520 6521-6540 6541-6560 6561-6580 6581-6600 6601-6620 6621-6640 6641-6660 6661-6680 6681-6700 6701-6720 6721-6740 6741-6760 6761-6780 6781-6800 6801-6820 6821-6840 6841-6860 6861-6880 6881-6900 6901-6920 6921-6940 6941-6960 6961-6980 6981-7000 7001-7020 7021-7040 7041-7060 7061-7080 7081-7100 7101-7120 7121-7140 7141-7160 7161-7180 7181-7200 7201-7220 7221-7240 7241-7260 7261-7280 7281-7300 7301-7320 7321-7340 7341-7360 7361-7380 7381-7400 7401-7420 7421-7440 7441-7460 7461-7480 7481-7500 7501-7520 7521-7540 7541-7560 7561-7580 7581-7600 7601-7620 7621-7640 7641-7660 7661-7680 7681-7700 7701-7720 7721-7740 7741-7760 7761-7780 7781-7800 7801-7820 7821-7840 7841-7860 7861-7880 7881-7900 7901-7920 7921-7940 7941-7960 7961-7980 7981-8000 8001-8020 8021-8040 8041-8060 8061-8080 8081-8100 8101-8120 8121-8140 8141-8160 8161-8180 8181-8200 8201-8220 8221-8240 8241-8260 8261-8280 8281-8300 8301-8320 8321-8340 8341-8360 8361-8380 8381-8400 8401-

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>5611-Oak Place</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Albert Tatum King</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1966</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/30/05</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mail Guard</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles E. King</u> | | 14. MOTHER'S MAIDEN NAME <u>Sophie Tatum</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>215-38-4826</u> | |
| 17. INFORMANT <u>Wife</u> | | Address <u>Same as Item 2.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PRIMARY LUNG CANCER</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>3 MONTHS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>66</u> , to <u>Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 8</u> , 19 <u>66</u> , and that death occurred at <u>5:45</u> M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>Leo I. Donovan</u> | | 22b. DATE SIGNED <u>11/8/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DR LEO I. DONOVAN</u> | | 22d. ADDRESS <u>8214 WISCONSIN AVE BETHESDA MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-14-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>DATE NOV 18 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT. **M**

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>11214 Metaculus St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Loretta Elizabeth King</u> | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 20 1914</u> |
| 9. AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u> Hours <u>2</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James O'Donnell</u> | | 14. MOTHER'S MARDEN NAME <u>Elizabeth M. McGoff</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>144-01-5785</u> | |
| 17. INFORMANT <u>Bernadette E. King</u> | | Address <u>11214 Metaculus St. Kensington, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty metamorphosis severe with cirrhosis</u> DUE TO <u>3221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute and chronic alcoholism</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 years?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my apinian death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John S. Ball</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>John S. Ball</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 3976 Old Georgetown Rd., Beth., Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 14, 1966.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 17, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>Glen Carter</u> | | ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | |
| 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>NOV 18 1966</u> | | | |

1988

FOR STATE
 HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u> | | d. STREET ADDRESS <u>9528 Riley Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>ALANSON</u> First <u>MILLEN</u> Middle <u>KITT</u> Last <u>REDGE</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 16, 1910</u> 56 68 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Projectionist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wine and Theaters</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Herman E. Kittredge</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>Yes</u> | |
| 17. INFORMANT <u>Uelaria Kittredge</u> Address <u>9528 Riley Road, Silver Spring, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute coronary insufficiency</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u>lost.</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Keap</u> EXAMINER'S NAME (Type) <u>BELDEN R. KEAP MD.</u> | | 22. DATE SIGNED <u>Nov. 20, 1966</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 25, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Clark E. Wilson</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Nov 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 149 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lancaster d. STREET ADDRESS 1457 Hiemenz Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Michael Last Kobland | | | | | | 4. DATE OF DEATH Month November Day 23 Year 1966 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 7, 1943 | | 9. AGE (In years last birthday) 23 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months 23 Days 23 Hours 23 Mins. 23 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph M. Kobland | | | | | | 14. MOTHER'S MAIDEN NAME Mary Grooby | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 189-34-8393 | | 17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphoblastic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours 28 Months | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 27 June , 1966, to 23 Nov. , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 23 Nov. , 1966, and that death occurred at 11:55 from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Norman S. Lichtenstein M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 24 Nov. 1966 | | | |
| 22c. PHYSICIAN'S NAME (Type) Norman S. Lichtenstein, MD. | | | | | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 11-25-66 | | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | | 23d. LOCATION (City, town or county) (State) Lancaster, Penna. | | | |
| 24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | 25a. REC'D BY REGISTRAR NOV 28 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>LOUDON</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Damascus</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aldie</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Highway Route 67. Cedar Grove.</u> | | d. STREET ADDRESS <u>Rt 1 Box 40</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>RAY</u> Last <u>LAWSON</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1966</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 2, 1939</u> |
| 9. AGE (In years last birthday) <u>27</u> | | 10. IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>H&B CATERING SERVICE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Walter Lawson</u> | | 14. MOTHER'S MAIDEN NAME <u>ARETHA Gibson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes, No</u> | | 16. SOCIAL SECURITY NO. <u>226-48-6013</u> | |
| 17. INFORMANT <u>PAULA LAWSON - wife</u> | | Address <u>add. same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>816.4</u> DUE TO <u>Injuries, multiple, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Automobile accident</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head-on collision - 2 cars -</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>7:45</u> p.m. <u>11/27</u> 19 <u>66</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway #27</u> | | 20f. (City or town) (County) (State) <u>Cedar Grove Mont. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John S. Ball</u> | | 22. DATE SIGNED <u>11/28/66</u> | |
| EXAMINER'S NAME (Type) <u>John S. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>11/28/66</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11-30-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Sterling</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Sterling VA.</u> | |
| 24. FUNERAL DIRECTOR <u>Raymond Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>DEC 1 1966</u> | |

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15230

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

15889

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15891

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Emory Grove Road</u> | | d. STREET ADDRESS <u>Emory Grove Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Jeffrey Ronald Lee</u> | | 4. DATE OF DEATH Month Day Year <u>November 21 1966</u> | |
| 5. SEX <u>m.</u> | 6. COLOR OR RACE <u>Negro.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 20 - 66</u> |
| 9. AGE (In years last birthday) <u>6</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. <u>6 1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Calvin Lee</u> | | 14. MOTHER'S MAIDEN NAME <u>Ethel Mc Elroy</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Ethel Lee</u> Address <u>same as above</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X Meningoencephalitis, Viral Interstitial pneumonitis diffuse with focal Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John S. Ball</u> M.D. | | 22. DATE SIGNED <u>11/22/66</u> | |
| EXAMINER'S NAME (Type) <u>John S. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Rockville Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 23b. DATE THEREOF <u>11/24/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg Md</u> |
| 24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>NOV 28 1966</u> | | | |

6-160162

12221

12221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15890

CERTIFICATE OF DEATH

15892

| | | | | | | | | |
|---|----------------------------------|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> | | | c. LENGTH OF STAY IN 1b <u>2 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u> | | | | d. STREET ADDRESS <u>13416 Parkland Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>D</u> Last <u>Lemmon</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>19 66</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 17, 1889</u> | | 9. AGE (In years last birthday) yrs. <u>77</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N. Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 13. FATHER'S NAME <u>William Bernhardt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Howard</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>none</u> | | 16. SOCIAL SECURITY NO. <u>072-05-6855B</u> | | 17. INFORMANT <u>Harry Lemmon</u> Address <u>13416 Parkland Drive Silver Spring, Maryland</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ARTERIO SCLEROTIC CARDIO VASC. DISEASE</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>NOV 8, 1966</u> to <u>NOV 12, 1966</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>NOV 12 1966</u> and that death occurred at <u>1033</u> M, from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <u>Walter E. Goetz</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Walter E. Goetz</u> | | | | 22d. ADDRESS <u>2390 Glenmont Circle, Wheaton, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 18, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Kensico Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>White Plains, N. Y.</u> | | |
| 24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 18 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

15895

15895

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF VITAL STATISTICS

| | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|---------------|--|------|--|-------|--|----------------|--|----------------|--|----------------|--|---------------|--|---------------|--|------------------------|--|------------------------|--|
| Name of deceased | | Date of birth | | Sex | | Race | | Marital status | | Cause of death | | Place of death | | Date of death | | Time of death | | Signature of physician | | Signature of registrar | |
| John Doe | | 1900-01-01 | | Male | | White | | Married | | Heart disease | | Home | | 1980-01-01 | | 10:00 AM | | John Doe, M.D. | | Jane Doe, Registrar | |
| Place of birth | | Date of death | | Sex | | Race | | Marital status | | Cause of death | | Place of death | | Date of death | | Time of death | | Signature of physician | | Signature of registrar | |
| New York City, N.Y. | | 1980-01-01 | | Male | | White | | Married | | Heart disease | | Home | | 1980-01-01 | | 10:00 AM | | John Doe, M.D. | | Jane Doe, Registrar | |
| Place of birth | | Date of death | | Sex | | Race | | Marital status | | Cause of death | | Place of death | | Date of death | | Time of death | | Signature of physician | | Signature of registrar | |
| New York City, N.Y. | | 1980-01-01 | | Male | | White | | Married | | Heart disease | | Home | | 1980-01-01 | | 10:00 AM | | John Doe, M.D. | | Jane Doe, Registrar | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15891

15893

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mass. | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wesley | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kensington Gardens | | | | d. STREET ADDRESS 72 Cheserton Rd. | | | |
| 3. NAME OF DECEASED (Type or print) OSCAR | | | | 4. DATE OF DEATH 11/12/66 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/22/91 | |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Mass. | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Mass. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Ruel A. Lowe | | | | 14. MOTHER'S MAIDEN NAME Mary Park | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Russell Lowe-son | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4281 DUE TO Unperceived Infarction (b) DUE TO Generalized Arterial Thromboses (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dissecting Aneurysm | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1966, to Nov 13, 1966 that (I) (we) last saw the deceased alive on Nov 13, 1966, and that death occurred at 8 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John J. Curry | | | | 22b. DATE SIGNED Nov 14 1966 | | 22c. PHYSICIAN'S NAME (Type) John J. Curry | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit | | | | 23b. DATE THEREOF 11/14/66 | | 23c. NAME OF CEMETERY OR CREMATORY Dell Park Cemetery | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | | | 25a. REC'D BY REGISTRAR DATE NOV 15 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |
| 23d. LOCATION (City, town or county) (State) Natick, Massachusetts | | | | 23e. ADDRESS | | | |

15499

15499

name.

Montgomery

Leslie

Washington

Washington

Washington

1/12/66

1/12/66

1/12/66

1/12/66

name.

name.

name.

name.

name.

name.

Section, Washington

Cell Block Cemetery

at-Transit, 1/12/66

1/12/66

1/12/66

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

FOR STATE
HEALTH DEPT.

15892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15894

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Morris c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mendham (Mendham) d. STREET ADDRESS Talmadge Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIAM FRANCIS LOWERY First Middle Last 4. DATE OF DEATH 11-29 Month Day Year 1966 | | 5. SEX M 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11-15-77 9. AGE (In years last birthday) yrs. 89 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Self employed 11. BIRTHPLACE (State or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? Amer. U.S.A. | | 13. FATHER'S NAME Thomas Lowery 14. MOTHER'S MAIDEN NAME Sara Stephenson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 139-26-6291 17. INFORMANT Bailey Funeral Home Hosp. Records Address Mendham, New Jersey | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arteriosclerotic heart disease with DUE TO cardiomegaly and congestive heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) failure; Bronchopneumonia (c) failure; Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Belden R. Reap M.D. EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 11/29/1966 22. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2 Dec 1966 23c. NAME OF CEMETERY OR CREMATORY Mendham Cemetery 23d. LOCATION (City or Town) (County) (State) Mendham, New Jersey | | 24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md. 25a. REC'D BY REGISTRAR DATE DEC 5 1966 25b. REGISTRAR'S SIGNATURE Charles Judge | |

12231

12231

12231

Handwritten signature or text at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15893

15895

| | | | | | | | | |
|---|--|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) | | | c. LENGTH OF STAY IN 1b 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital | | | | d. STREET ADDRESS 8108 D'Arcy Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Jennifer Middle Jean Last MADDEN | | | | 4. DATE OF DEATH Month November Day 10 Year 1966 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cauc. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 22, 1966 | | |
| 9. AGE (In years last birthday) yrs. 7 | | 10. IF UNDER 1 YEAR Months 7 Days 18 | | 11. IF UNDER 24 HRS. Hours 18 Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | | 11. BIRTHPLACE (County & State, or foreign country) Hyannis, Massachusetts | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James W. Madden | | | | 14. MOTHER'S MAIDEN NAME Constance P. Ford | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A | | 16. SOCIAL SECURITY NO. N/A | | 17. INFORMANT Forestville Address Md. Captain James W. Madden, 8108 D'Arcy Road | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Mal-function DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that the (this hospital) attended the deceased from Nov. 7 , 19 66 , to Nov. 10 , 19 66 , that the (we) last saw the deceased alive on Nov. 10 , 19 66 , and that death occurred at 936 M, from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <i>Jerry J. Tomasovic</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED Nov. 10, 1966 | | |
| 22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic CAPT MC USAF | | | | 22d. ADDRESS Naval Hospital, Bethesda, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/13/66 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) Orleans, Massachusetts | | |
| 24. FUNERAL DIRECTOR Rinaldi Funeral Home ADDRESS 7400 Georgia Ave., N.W. Washington, D. C. | | | | 25a. REC'D BY REGISTRAR DATE NOV 14 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

6-58

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15051

1992

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2725

Interest level

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doi:

Example 1

Cons.

A35

1995-2000, 2001-2006, 2007-2012

Continued on p. 100

644

A/E

A 22

CONFIDENTIAL

Herbert H. Goldhamer

Original: Not required

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

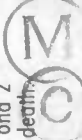
112035: *Worms* I. Horn

1400 Georgia Ave. N.W., Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15894

CERTIFICATE OF DEATH

15896

| | | | | | | | |
|---|--|---|---|---|---|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk, Virginia 83-3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 7416 West Kenmore Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ross Daniel MAKI | | | | 4. DATE OF DEATH Month Day Year November 5 19 66 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Cauc | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 30 October 1966 | |
| 9. AGE (In years last birthday) yrs. 6 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA | | 10b. KIND OF BUSINESS OR INDUSTRY NA | | 11. BIRTHPLACE (County & State, or foreign country) Portsmouth, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME David Maki | | | |
| 14. MOTHER'S MAIDEN NAME Carol Doup | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. NA | | | | 17. INFORMANT Address David Maki 7416 West Kenmore Dr. Norfolk, Va | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple congenital heart defects 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from 4 November 1966 , to 5 November 1966 , that (X) (we) last saw the deceased alive on 5 November 1966 , and that death occurred at 12:30 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8 Nov 66 | |
| 22c. PHYSICIAN'S NAME (Type) A. E. POMPKINS, M.D. | | | | 22d. ADDRESS U. S. NAVAL HOSPITAL, BETHESDA, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10 Nov. 66 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR Arlington Funeral Home 3901 North Fairfax Drive, Arlington, Va. | | | | 25a. REC'D BY REGISTRAR NOV 14 1966 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

15888

15888

Virginia

Montgomery

Richmond, Virginia

1 day

Leeds (Hunt)

This West Virginia Drive

U. S. Naval Hospital, Bethesda, Md.

November 2, 1945

MAIL

United

Post

Card

Index

October 1945

Postmaster, Virginia

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15

Carol Damp

David Lark

David Lark, 101 West Monroe St., Norfolk, Va.

15

15

Multiple alphabetical name details

U. S. NAVAL HOSPITAL, BETHESDA, MD.

A. E. JOHNSON, M.D.

10 No. 66 Arlington National Cemetery, Arlington, Virginia

Index

Arlington National Cemetery

101 West Monroe Drive, Norfolk, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician. Page 5 to be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
COUNTY
MONTGOMERY
M
CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Westmoreland Hills
C. LENGTH OF STAY IN 1b
2.5 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
4512 Wetherill Road
00

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | |
| 15895 | | 15897 | |
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | |
| a. STATE <u>Maryland</u> | | b. COUNTY <u>Montgomery</u> | |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | |
| <u>Westmoreland Hills</u> | | <u>Westmoreland Hills</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | d. STREET ADDRESS | |
| <u>4512 Wetherill Road</u> | | <u>4512 Wetherill Rd</u> | |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | |
| First Middle Last <u>Claude Russell Marshall</u> | | Month Day Year <u>November 10 1966</u> | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH |
| <u>Male</u> | <u>White</u> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <u>Nov. 14, 1892</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) | 12. CITIZEN OF WHAT COUNTRY? |
| <u>Lawyer-Retired</u> | <u>U.S. Government</u> | <u>73 yrs.</u> | <u>U.S.A.</u> |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | |
| <u>Thomas Davis Marshall</u> | <u>Marian Spearman</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | |
| <u>Yes</u> | <u>World War II - 1915 577-60-3094</u> | <u>Rowland S. Marshall - Brother</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> | | <u>1 yr - 8 mo.</u> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) <u>Carcinoma sigmoid</u> | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? | |
| <u>Diabetes mellitus</u> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 1965</u> to <u>November 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>November 10, 1966</u> , and that death occurred at <u>10:AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE | 22b. DATE SIGNED | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| <u>E. Clarence Rice</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS | | |
| <u>E. CLARENCE RICE</u> | <u>1150 Conn. Ave. N.W., Washington D.C.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
| <u>Burial</u> | <u>11-14-1966</u> | <u>Fort Lincoln Cemetery</u> | <u>Prince Georges Co., Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | 25. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| <u>Joseph Gawler's Sons, Inc.</u> | | <u>Nov 18 1966</u> | <u>Charles Judge</u> |

15883

15883

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15896

15898

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. LENGTH OF STAY IN 1b <u>2 hrs</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Anthony Dominic Martinelli</u> First Middle Last | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1966</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-3-1897</u> | |
| 9. AGE (In years lost birthday) <u>69</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | 11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Antique Refinisher</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shoreham Hotel</u> | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Giacomo Martinelli</u> <u>Giacomo Martinelli</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marguerite Lorusso</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u> | | | | 16. SOCIAL SECURITY NO. <u>127-10-7276</u> | | | |
| 17. INFORMANT <u>Theresa Martinelli</u> | | | | Address <u>9107 Warren St., S. S.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>433.0</u> DUE TO <u>Arterio-sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intermittent Acute Congestive Heart Failure - Cardiac Arrhythmia</u> (c) <u>Diabetes Mellitus (Fibillation Heart Block)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>1 year</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>66</u> , to <u>Nov 24</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Sept 5</u> , 19 <u>66</u> , and that death occurred at <u>12:40</u> P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>George L Ball</u> | | | | 22b. DATE SIGNED <u>Nov 24, 1966</u> | | 22c. PHYSICIAN'S NAME (Type) <u>George L Ball</u> | |
| 22d. ADDRESS <u>10620 Georgia Ave Silver Spring Md</u> | | | | 22e. REC'D BY REGISTRAR <u>NOV 28 1966</u> | | 22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 28, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u> | |
| 24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner & Humphrey, Inc.</u> | | | | 25. ADDRESS <u>8434 Georgia Ave Silver Spring, Md.</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 12 hours after death.

I certify that the above information was obtained from the attending physician and the deceased's next of kin, and that the information is true and correct. I am a duly licensed funeral home operator in the State of Maryland. My name is Charles Judge and my address is 10620 Georgia Ave Silver Spring Md.

79221

12826

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15897

CERTIFICATE OF DEATH

15899

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYAN'S ROAD, Md. | |
| c. LENGTH OF STAY IN 1b 10 days / 5 hr | | d. STREET ADDRESS P.O. Box 11, Bryans Rd. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William Foster Massey | | 4. DATE OF DEATH November 6, 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 21, 1886 |
| 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR Months 1 Days 16 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Auto Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Md. | |
| 11. BIRTHPLACE (County & State, or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Massey | | 14. MOTHER'S MAIDEN NAME Mary Foster | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 578-18-6007-A | |
| 17. INFORMANT Hospital Records | | Address 7600 Carroll Ave. | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstruction of bronchus DUE TO Branchogenic carcinoma (c) Branchogenic carcinoma | | INTERVAL BETWEEN ONSET AND DEATH days days Months |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Colostomy - growth rectum ② BPH - hist. of | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
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|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

21. I certify that (I) (this hospital) attended the deceased from **10-26, 1966** to **11-5, 1966** that (I) (we) last saw the deceased alive on **11-5-1966**, and that death occurred at **12:30 M.** from causes and on the date stated above.

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| 22a. SIGNATURE Kenneth Cruze | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 11/6/1966 |
| 22c. PHYSICIAN'S NAME (Type) KENNETH CRUZE, M.D. | 22d. ADDRESS WASHINGTON SANITARIUM, TAKOMA PARK | |

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|--|---------------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11/9/1966 | 23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens Cem. Waldorf, Md. | 23d. LOCATION (City or Town) (County) (State) |
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| 24. FUNERAL DIRECTOR Hyman & F. Horne | ADDRESS 1300 N. N. St. | 25a. REC'D BY REGISTRAR Charles Judge | 25b. REGISTRAR'S SIGNATURE Charles Judge |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15900

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|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u> | | c. LENGTH OF STAY IN lb <u>30 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O. Boyd</u> | | d. STREET ADDRESS <u>P.O. Boyd</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Francis</u> Last <u>Maughlin</u> | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1966</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 15 1909</u> |
| 9. AGE (In years lost birthday) <u>57</u> yrs. | | IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>German town</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>E. Glenn Boland</u> | | 14. MOTHER'S MAIDEN NAME <u>Elith Walsh</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>David a. Maughlin</u> | | Address <u>Boyd</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Hepatitis - Chronic</u> DUE TO (c) <u>Alcoholism. Chronic</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1 Year</u> <u>Years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | 22. DATE SIGNED <u>Nov-9, 1966</u> | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-11-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Church</u> | 23d. LOCATION (City or Town) (County) (State) <u>Boyd</u> <u>Montgomery</u> <u>Md</u> |
| 24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> | | 25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Ernest C. Gartner</u> | | 25c. REGISTRAR'S SIGNATURE <u>Ernest C. Gartner</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|---|---------------------------------|---|--|--|--|---|-------------------------|---|--|
| 15899 | | | | | | | | | | 15901 | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. CDUNITY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. LENGTH OF STAY IN 1b <u>20 min</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7400 18th Ave #206 16.2</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u> | | | | | | d. STREET ADDRESS <u>Hyattsville</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last <u>May</u> | | | 4. DATE OF DEATH Month Day Year <u>11 - 24 19 66</u> | | | 5. SEX <u>Female</u> | | |
| 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-24-66</u> | | 9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>20</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County Maryland</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | |
| 13. FATHER'S NAME <u>LLOYD MAY</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Carol Theresa Howard</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple congenital anomalies</u> 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary atelectasis</u> DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> , 19 <u>66</u> to <u>11/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/24 19 66</u> , and that death occurred at <u>5:20</u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Irwin W. Rowner</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/24/66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>IRWIN W. ROWNER</u> | | | | | | 22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/28/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> | | | | | | ADDRESS <u>1331 Rockville Pike</u> <u>Rockville, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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Multiple congenital anomalies

Tuberculous aetiology

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... of ...

... of ...

CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>15.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | d. STREET ADDRESS <u>3932 Lantern Dr.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>MARGUERITE E. McCaleb</u> | | 4. DATE OF DEATH <u>11-25-66</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/6/94</u> |
| 9. AGE (In years lost birthday) <u>72</u> yrs. | | 10. IF UNDER 1 YEAR Months Ooys Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel Swartz</u> | | 14. MOTHER'S MAIDEN NAME <u>Claudia Moore</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>- - -</u> | |
| 17. INFORMANT <u>Eugene McCaleb (Same as No. 2)</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>UNKNOWN</u> <u>NUMBER OF YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> , 19 <u>66</u> , to <u>11-25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-25</u> , 19 <u>66</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Michael Madeoff</u> | | 22b. DATE SIGNED <u>11-26-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MICHAEL MADEOFF</u> | | 22d. ADDRESS <u>10620 Georgia Ave SILVER SPRING</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 23b. DATE THEREOF <u>11/28/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National Meo. Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Wash., D.C. 20016</u> | | 25a. REC'D BY REGISTRAR <u>DEC 1 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15302

CERTIFICATE OF DEATH

15300

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|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Birth | | Sex | |
| Age | | Date of Death | | Place of Death | |
| Cause of Death | | Occupation | | Residence | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | |
| Date of Registration | | Place of Registration | | Signature of Registrar | |

THIS CERTIFICATE OF DEATH IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY OF NEW YORK, ON THE _____ DAY OF _____, 19____.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15901

CERTIFICATE OF DEATH

15903

| | | | | | | | |
|---|---|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | c. LENGTH OF STAY IN 1b 4 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital | | | | d. STREET ADDRESS Montgomery General Hospital 2600 Rockledge Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle Robert Last McDonald | | | | 4. DATE OF DEATH Month 11 Day 7 Year 1966 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/13/84 | | 9. AGE (In years last birthday) yrs. 82 | IF UNDER 1 YEAR Months 15 Days 1 | IF UNDER 24 HRS. Hours 1 Min. 15 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | 11. BIRTHPLACE (County & State, or foreign country) Pittsburg, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John R. McDonald | | | | 14. MOTHER'S MAIDEN NAME Mary Joyce | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. 218-50-52507 | | 17. INFORMANT John R. McDonald Jr. Address 2 Manchester Pl., S.S., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 5400 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Multiple gastric & duodenal ulcers DUE TO 1+ yrs (c) Gastro intestinal of Acumshere secondary to one 1+ yrs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Abdominal aortic aneurysm, calcified, aneurysm, disease | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 64 , to 11/7 , 19 66 , that (I) (we) last saw the deceased alive on 11/7 , 19 66 , and that death occurred at 5:50 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A. Dement Bonifant | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) A. Dement Bonifant | | | | 22d. ADDRESS Medical Center, Olney, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Nov. 10, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Humphrey, Inc. | | ADDRESS 8434 Georgia Ave. Silver Spring, Md. | | 25a. REC'D BY REGISTRAR NOV 14 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12901

12901

CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Birth | | Date of Death | |
| Sex | | Race | | Place of Birth | |
| Marital Status | | Occupation | | Cause of Death | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | |
| Date of Issuance | | Place of Issuance | | Official Seal | |

Vertical text on the right margin, likely a filing or archival stamp.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G382 11/10/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15902

15904

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u> | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | | d. STREET ADDRESS <u>RFD #2</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>BERTIE</u> Middle <u>S</u> Last <u>McGowan</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>1966</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept 3, 1895</u> | |
| 9. AGE (In years lost birthday) yrs. <u>71</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Wm Reynolds</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Daisy Morrison</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <u>Pauline Hutchinson</u> Address <u>1524 1054 Rockville, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction Recent and Remote</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary arteriosclerosis, severe</u> DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. EXAMINER'S NAME (Type) <u>John G. Ball</u> | | | | 22. DATE SIGNED 11/2/66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>11/5/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Dargan, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>NOV 3 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15903

Item 9 Film G382 11/21/66 mh

CERTIFICATE OF DEATH

15905

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | | c. LENGTH OF STAY IN 1b <u>15.1</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u> | | | | d. STREET ADDRESS <u>100 THOMAS STREET</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>G.</u> Last <u>MEDLEY JR.</u> | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1966</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/31/1897</u> 69 yrs. | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u> Hours <u>19</u> Min. <u>66</u> | | IF UNDER 24 HRS. Months <u>11</u> Days <u>10</u> Hours <u>19</u> Min. <u>66</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Sales Promotion</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>John George Medley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>KATIE VAN ALST</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>052-05-5211</u> | | 17. INFORMANT <u>Mrs. Mary B. Medley</u> Address <u>100 Thomas St Rockville Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal insufficiency</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerotic brain disease</u> DUE TO (c) <u>dementia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diastolic hypertension</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) <u>Rockville</u> <u>MD</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-10-66</u> , 19 <u>66</u> , to <u>Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-10-66</u> , and that death occurred at <u>12 P.</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Bernard A Fitzgerald</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11-10-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u> | | | | 22d. ADDRESS <u>217 UNIV. BLVD. S.E., Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/14/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Date of Heaven</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Montg Md</u> | |
| 24. FUNERAL DIRECTOR <u>William C. Helth</u> | | | | ADDRESS <u>Baltimore, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 16 1966</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15904

CERTIFICATE OF DEATH

15906

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|---|-------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16.2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u> | | | d. STREET ADDRESS <u>7912 24th Place</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Eileen</u> Middle <u>Ethel</u> Last <u>Merryman</u> | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1966</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-27-1918</u> | | 9. AGE (In years lost birthday) <u>48</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Thomas Welsh</u> | | | 14. MOTHER'S MAIDEN NAME <u>Harriett E. Carpenter</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mr. Clarence Merryman</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>47</u> , to <u>10-2</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9/30</u> 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>Chas. V. Pate</u> | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) <u>Charles V. Pate M.D.</u> |
| 22d. ADDRESS <u>4th & W St. N.E. Wash.D.C.</u> | | | 22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11/5/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Colar Manor Md</u> | |
| 24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u> | | | 25. REC'D BY REGISTRAR <u>NOV 1966</u> | | |
| 26. ADDRESS <u>3004 ST. N.E.</u> | | | 27. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

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RECORDS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 2, 11, 12 Film G382 11/17/66 mh

15905

CERTIFICATE OF DEATH

15907

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> Baldwin 03-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>11111 N. RAINING HILL RD</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>P.</u> Last <u>MEYERS</u> | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 18, 1881</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper - retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Meyers</u> | | 14. MOTHER'S MAIDEN NAME <u>Fianna Mumma</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address <u>Asburg Methodist Home Gaithersburg, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u> | | INTERVAL BETWEEN ONSET OF DEATH <u>7 days</u> <u>10 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis, mod. adv. inactive</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19___, to <u>11/11/66</u> , 19___, that (I) (we) last saw the deceased alive on <u>11/11/66</u> , 19___, and that death occurred at <u>2:00 P.</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Henry C. Scruggs MD.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/11/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD.</u> | | 22d. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/14/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Wilson Methodist Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Long Green, Md. Balto.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons, Inc.</u> ADDRESS <u>3121 North & Penna. Aves</u> | | 25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> DATE | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 15906 | | | | | 15908 | | | | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | | | | |
| a. COUNTY <u>Montgomery</u> | | | | | b. COUNTY <u>DC</u> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC</u> | | | | | | | | | |
| c. LENGTH OF STAY IN 1b <u>11-25-64 to 11-9-66</u> | | | | | d. STREET ADDRESS <u>344 Raleigh Street S.E.</u> | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery Convalescent Home</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>John Henry Miller</u> | | | 4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1966</u> | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | | 6. COLOR OR RACE <u>White</u> | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 8. DATE OF BIRTH <u>June 14, 1901</u> | | | | | |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u> | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur - Land Brinks Co Private</u> | | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Maryland</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | |
| 13. FATHER'S NAME <u>Harvey Miller</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Alice Strine</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT <u>Bright L. Miller - 303 - Parkland Pl. SE</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u> | | | | | | | | | | <u>12 hr</u> | | | | |
| 4221 DUE TO (b) <u>Apoplexy, hemorrhagic, old</u> | | | | | | | | | | <u>5 yr</u> | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arterio-sclerotic changes coronary arteries</u> | | | | | | | | | | <u>10 yr</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>66</u> , to <u>11/9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> , 19 <u>66</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>A.D. B. BAUFANT</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>Nov. 9-1966</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>A.D. B. BAUFANT</u> | | | | | 22d. ADDRESS <u>Silver Spring, MD.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>Nov. 12-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | | 23d. LOCATION (City, town or county) (State) <u>Switzland Md.</u> | | | | | | |
| 24. FUNERAL DIRECTOR <u>Simmons Brothers Funeral Home</u> | | | | | ADDRESS <u>1661 Good Hope Rd. SE Wash. DC</u> | | 25a. RECEIVED BY REGISTRAR <u>NOV 14 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared to Dr. Kelly for Dr. Kelly to sign

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15907

CERTIFICATE OF DEATH

15909

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. George's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u> | | d. STREET ADDRESS <u>8260 New Hampshire Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Joseph</u> Middle <u>Miller</u> Last | | 4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-10-1894</u> |
| 9. AGE (In years lost birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months <u>16</u> Days <u>2</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Candy business</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Phila. Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Lawrence Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Angeline Repetto</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO. <u>204-14-5471</u> | |
| 17. INFORMANT <u>Jerris Cecela</u> Address <u>8260 New Hampshire Ave. S. S., Md.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 7, 1966</u> to <u>Nov. 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 7, 1966</u> , and that death occurred at <u>5:25</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas J. Kelly</u> | | 22b. DATE SIGNED <u>Nov. 25, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>THOMAS J. KELLY, M.D.</u> | | 22d. ADDRESS <u>6480 N. H. Ave., Takoma Park, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 29, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | DATE <u>DEC 1 1966</u> | |

15309

15307

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
CITY OF NEW YORK

[Faint, mostly illegible text from the reverse side of the document, including names and dates.]

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CERTIFICATE OF DEATH

Reg. Dist. No.

15910

15908

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| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | |
| c. LENGTH OF STAY IN 1b 1 Yr. 6 Mos. | | d. STREET ADDRESS 7205 - 47th Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CLARA Middle Bell Last MOBLEY | | 4. DATE OF DEATH Month Nov. Day 29, Year 19 66 | |
| 5. SEX F | 6. COLOR OF RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 4, 1877 |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months 10 Days 25 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Laytonsville, Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Silas A. Bell | | 14. MOTHER'S MAIDEN NAME E. Rebecca Cashell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-44-1639 | |
| 17. INFORMANT Kensington Gardens Records | | Address Same as Item 1 | |

| | | |
|---|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 260X DUE TO Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerosis DUE TO (c) 8 yrs 8 yrs | | INTERVAL BETWEEN ONSET AND DEATH 10 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) |
| 20g. (State) | | |
| 21. I certify that I attended the deceased from May 11/18, 1966 to Nov 29, 1966 , that I last saw the deceased alive on 4/29/66 , and that death occurred at 4:30 PM , from the causes and on the date stated above. | | |
| ADDRESS (Street, city or town, state) 5707 Wisconsin Ave | | DATE SIGNED 4/29/66 |
| ACTUAL SIGNATURE Frank Y. Jaggars Jr. | | M.D. FRANK Y. JAGGERS JR. Chevy Chase, Md. |
| PHYSICIAN'S NAME (Type) FRANK Y. JAGGERS JR. | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12-2-66 | 22c. NAME OF CEMETERY OR CREMATORY St. John's Church Cem. |
| 22d. LOCATION (City, town, or county) Olney, Maryland | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, | | ADDRESS Bethesda, Maryland |
| 24a. REC'D BY REGISTRAR DATE DEC 2 1966 | | 24b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15310

CERTIFICATE OF DEATH

18808

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|---|--|---|--|---|--|---|--|--|--|---|--|
| NAME OF DECEASED JAMES H. HARRIS | | AGE 45 | | SEX Male | | RACE White | | DATE OF DEATH Nov. 20, 1900 | | PLACE OF DEATH New York City | |
| CAUSE OF DEATH Diphtheria | | PERIOD OF ILLNESS 10 days | | NATURE OF DISEASE Acute | | LOCALITY OF DISEASE New York City | | HOSPITAL OR PLACE WHERE TREATED St. John's Hospital | | NAME OF PHYSICIAN Dr. J. H. Harris | |
| DATE OF BIRTH Nov. 20, 1855 | | PLACE OF BIRTH New York City | | MARRIAGE Married | | EDUCATION High School | | OCCUPATION Clerk | | RELIGION Roman Catholic | |
| NAME OF FATHER John H. Harris | | NAME OF MOTHER Mary H. Harris | | NAME OF SPOUSE Elizabeth H. Harris | | NAME OF CHILDREN None | | NAME OF OTHER RELATIVES None | | NAME OF NEXT OF KIN None | |
| NAME OF BURIAL PLACE St. John's Cemetery | | NAME OF BURIAL PLACE St. John's Cemetery | | NAME OF BURIAL PLACE St. John's Cemetery | | NAME OF BURIAL PLACE St. John's Cemetery | | NAME OF BURIAL PLACE St. John's Cemetery | | NAME OF BURIAL PLACE St. John's Cemetery | |

1. The death of James H. Harris, aged 45, male, white, was caused by diphtheria, which was contracted in New York City, and which was attended by St. John's Hospital, where he died on November 20, 1900. The disease was of the acute type, and was attended by St. John's Hospital, where he died on November 20, 1900. The disease was of the acute type, and was attended by St. John's Hospital, where he died on November 20, 1900.

15909

CERTIFICATE OF DEATH

15911

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 8 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6917 Wilson Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BERTHA C. MOORE | | 4. DATE OF DEATH Month Nov. Day 9, Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 9, 1880 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Indiana | |
| 11. BIRTHPLACE (County & State, or foreign country) U. S. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME William Cates | | 14. MOTHER'S MAIDEN NAME Lavinia LaForge | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 304-09-1682 | |
| 17. INFORMANT Daughter | | Address Mrs. Edward Nell, Jr. Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary atherosclerosis DUE TO (c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH minutes years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 11-9 , 19 66 , that (I) (we) last saw the deceased alive on 10-26 19 66 , and that death occurred at 10A M, from causes and on the date stated above | | | |
| 22a. SIGNATURE Russell M. Tilley, Jr. M.D. | | 22b. DATE SIGNED 11-9-66 | |
| 22c. PHYSICIAN'S NAME (Type) RUSSELL M. TILLEY, JR. | | 22d. ADDRESS 4701 Mass. Ave., N. W. Washington, D. C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11-12-66 | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | 23d. LOCATION (City or Town) (County) (State) Washington, D. C. |
| 24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland | | 25. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15910

CERTIFICATE OF DEATH

15912

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium | | d. STREET ADDRESS 3911 Bradley Lane | |
| 3. NAME OF DECEASED (Type or print) First RUTH Middle C. Last MOORE | | 4. DATE OF DEATH Month NOVEMBER Day 22 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 16, 1890 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months 7 Days 6 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John R. Collette | | 14. MOTHER'S MAIDEN NAME Ella L. Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-52-6000 | |
| 17. INFORMANT Mrs. J.F. Yriart, Dtr., Same as #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL SCLEROSIS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from AUG. 22, 1966 , to NOV. 22, 1966 , that (I) (we) last saw the deceased alive on NOV. 22, 1966 , and that death occurred at 2:54 A.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Henry M. Lowden | | 22b. DATE SIGNED 11/22/66 | |
| 22c. PHYSICIAN'S NAME (Type) HENRY M. LOWDEN, M.D. | | 22d. ADDRESS 5206 Norway Dr. Chevy Chase, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11/23/66 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | 23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C. | | 25. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15911

CERTIFICATE OF DEATH

15913

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, 1</u> | |
| c. LENGTH OF STAY IN TB <u>12 days</u> | | d. STREET ADDRESS <u>5808 Greentree Road</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Philip S. Moorhead</u> | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1966</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-26-96</u> |
| 9. AGE (In years lost birthday) yrs. <u>70</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Comptroller</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Duckstone Co.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Danville, Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Moorhead</u> | | 14. MOTHER'S MAIDEN NAME <u>Leiscilla Shay</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>W.W.I.</u> | | 16. SOCIAL SECURITY NO. <u>577-03-3035</u> | |
| 17. INFORMANT <u>Wacker Gary Moorhead (son)</u> | | 18. ADDRESS <u>5808 Greentree Road Bethesda, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Continuous massive Esophageal hemorrhage, shock.</u> DUE TO (b) <u>ruptured varices, hiatal hernia, + proctitis</u> DUE TO (c) <u>peptic esophagitis.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>previous cholecystectomy and re-exploration for bloody stools, pulmonary edema.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 31</u> , 19 <u>66</u> , to <u>Nov. 9</u> , 19 <u>66</u> , that (I) <u>did</u> last saw the deceased alive on <u>Nov. 9</u> , 19 <u>66</u> , and that death occurred at <u>10:00</u> a.m., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Linwood H. Johnson Jr.</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>11-10-66</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>Linwood H. Johnson Jr.</u> | | 22d. ADDRESS <u>4405 E-W Highway Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-14-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 18 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15912

CERTIFICATE OF DEATH

15914

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>4700-Waverly Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Thomas Dudley Mote</u> | | 4. DATE OF DEATH <u>Nov. 5 1966</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 23 1918</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales man</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>furniture</u> | 9. AGE (In years last birthday) <u>48</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James P. Mote</u> | | 14. MOTHER'S MAIDEN NAME <u>Thelma Murray</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW II Army</u> | | 16. SOCIAL SECURITY NO. <u>720-12-1171</u> | |
| 17. INFORMANT <u>Page Mote</u> | | Address <u>same as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>Cardiac hemorrhage (intercoronary thrombosis)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Fatty liver</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> , 19 <u>66</u> to <u>11/5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/5</u> , 19 <u>66</u> and that death occurred at <u>7:30</u> M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Marvin Wadler</u> | | 22b. DATE SIGNED <u>11/6/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u> | | 22d. ADDRESS <u>8218 Wine Av. Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11/10/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington, National</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u> |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| Address <u>7551 Wisconsin Av. Bethesda, Md.</u> | | DATE <u>NOV 14 1966</u> | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

15915

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|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> 151 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10204 McKenney Ave.</i> | | d. STREET ADDRESS <i>10204 McKenney Ave.</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>ALVERDA</i> Middle <i>M</i> Last <i>MOYER</i> | | 4. DATE OF DEATH Month <i>11</i> Day <i>7</i> Year <i>1966</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6-26-1874</i> |
| 9. AGE (In years last birthday) <i>92</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Samuel McCloy</i> | | 14. MOTHER'S MAIDEN NAME <i>Lydia Ann Morris</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| INFORMANT <i>Thomas E. Moyer</i> | | 10204 McKenney Ave. Silver Spring Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal pulmonary congestion</i> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>chronic myocarditis</i> DUE TO (c) <i>chronic cardiovascular disease</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>JULY 18 1940</i> to <i>NOV 7 1966</i> that I last saw the deceased alive on <i>NOV. 7, 1966</i> and that death occurred at <i>1:52 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Edgar E. Quayle</i> M.D. | | ADDRESS (Street, city or town, state) <i>1822 Biltmore St. N.W.</i> DATE SIGNED <i>11/7/66</i> | |
| PHYSICIAN'S NAME (Type) <i>Edgar E. Quayle</i> M.D. | | Washington, D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 22b. DATE THEREOF <i>11/10/66</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> | | ADDRESS <i>2901 14th St. N.W.</i> | |
| 24a. REC'D BY REGISTRAR <i>NOV 9 1966</i> | | 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

15916

15914

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|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>8 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>1511</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8500 Dixon Avenue</u> | | | | d. STREET ADDRESS <u>8500 Dixon Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>FRANCIS</u> Middle <u>MURPHY</u> Last | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1966</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Cauc.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-21-03</u> 63 yrs. | |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> | | IF UNDER 24 HRS. Hours <u>11</u> Min. <u>25</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chiropractor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Francis Murphy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Stanton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>106-12-6439</u> | | 17. INFORMANT <u>Box 123, Bethesda, Md.</u> <u>Mrs. Isabelle Beart (sister)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 30, 1966</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 1, 1966</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

15818

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15818

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED <i>John J. Kennedy</i> | | 2. SEX <i>Male</i> | |
| 3. AGE <i>35</i> | | 4. OCCUPATION <i>Police Officer</i> | |
| 5. PLACE OF BIRTH <i>New York City</i> | | 6. DATE OF BIRTH <i>March 15, 1883</i> | |
| 7. PLACE OF DEATH <i>New York City</i> | | 8. DATE OF DEATH <i>March 18, 1918</i> | |
| 9. CAUSE OF DEATH <i>Pneumonia</i> | | 10. MANNER OF DEATH <i>Natural</i> | |
| 11. SIGNATURE OF EXAMINER <i>John J. Kennedy</i> | | 12. SIGNATURE OF WITNESSES <i>John J. Kennedy</i> | |
| 13. SIGNATURE OF CORONER <i>John J. Kennedy</i> | | 14. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 15. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 16. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 17. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 18. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 19. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 20. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 21. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 22. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 23. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 24. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 25. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 26. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 27. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 28. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
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| 31. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 32. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
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| 49. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 50. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
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| 53. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 54. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
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| 65. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 66. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
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| 81. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 82. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 83. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 84. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 85. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 86. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 87. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 88. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 89. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 90. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 91. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 92. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 93. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 94. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 95. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 96. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 97. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 98. SIGNATURE OF JURY <i>John J. Kennedy</i> | |
| 99. SIGNATURE OF JURY <i>John J. Kennedy</i> | | 100. SIGNATURE OF JURY <i>John J. Kennedy</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 15 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. | | b. COUNTY MONTGOMERY | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAIRLAND NURSING HOME | | | | e. STREET ADDRESS 1511 ROCKVILLE RD | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) ARTHUR | | First | | Middle LAPHAN | | Last MURRAY, JR. | | 4. DATE OF DEATH Month 11 Day 26 Year 1966 | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 8, 1906 | | 9. AGE (in years last birthday) 58 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Co. | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME ARTHUR L. MURRAY SR. | | | | 14. MOTHER'S MAIDEN NAME LILLIAN GUNTROM. | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 577-18-7244 | | 17. INFORMANT Son | | Address Same as Item 2. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Myeloma (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 20 hrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 , to 26 Nov, 1966 , that (I) (we) last saw the deceased alive on 26 Nov 1966 , and that death occurred at 9:15 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Merton L. White | | | | 22b. DATE SIGNED 26 Nov 66 | | 22c. PHYSICIAN'S NAME (Type) MERTON L. WHITE | | | |
| 22d. ADDRESS 9911 Georgia Ave Silver Spring, Md | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-30-66 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION (City, town or county) _____ (State) _____ Prince George County, Md. | | | |
| 24. FUNERAL DIRECTOR Arthur L. White | | | | 25a. REC'D BY REGISTRAR Bethesda, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION

15217

15218

Mar. 5, 1905

Washington, D. C.

Respected

Friend

Dear Sir:

Very respectfully,
Wm. Lincoln

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1
MAY 1966
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12/12/66 mh

15916

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

15918

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u> | | d. STREET ADDRESS <u>2408 Chapman Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>MARY E MURRAY</u> | | 4. DATE OF DEATH <u>Nov 29 1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 15 1917</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brass Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Schermethorn</u> | | 14. MOTHER'S MAIDEN NAME <u>Kathryn Billington</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-056487</u> | |
| 17. INFORMANT <u>John J. Murray</u> | | Address <u>Hyattsville, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>10 YRS</u> <u>10 YR</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>PROBABLE MESENTERIC ARTERY THROMBOSIS</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/26</u> , 19 <u>66</u> to <u>11/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/28</u> , 19 <u>66</u> , and that death occurred at <u>6:40</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Ronald W. Barr, M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR, M.D.</u> | | 22d. ADDRESS <u>10401 OLD GEORGETOWN RD BETHESDA, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec. 3, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Southland Bro Leo Md</u> | |
| 24. FUNERAL DIRECTOR <u>F. Sasse's Sons Hyattsville, Md</u> | | 25a. REC'D BY REGISTRAR <u>DEC 2 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

15012

15012



FOR STATE
HEALTH DEPT.

15917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15919

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u> | | d. STREET ADDRESS <u>3200 Morrison St. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>S</u> Last <u>Musick</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-27-95</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u>47</u> Min. <u>3</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Govt Printing Office</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Greensburg, Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Herbert M. Musick</u> | | 14. MOTHER'S MAIDEN NAME <u>Daisy Sheffler</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>Yes W.W.I</u> | | 16. SOCIAL SECURITY NO. <u>578-24-7655</u> | |
| 17. INFORMANT <u>Mrs Mary Musick</u> Address <u>Same (Wife)</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>823.4 Exsanguination; shock due to massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>intrathoracic hemorrhage due to multiple,</u> DUE TO (c) <u>extreme, internal injuries and fractures.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased was front seat passenger in car which left road and hit light pole when driver fell asleep.</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>1:15</u> Hour <u>11-4</u> a.m. <u>1966</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>at work</u> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> | | 20f. (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>Nov. 4, 1966</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Washington</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-9-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery, Arlington, Virginia</u> | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 10 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15012

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 15918 Items 4, 10, 21 Film G-582 11/16/66 mh 15920 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 29 Days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland | | | | e. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | | f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown | | | |
| g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 4. DATE OF DEATH Month November Day 6 Year 1966 | | | | 5. SEX Female | | | |
| 6. COLOR OR RACE White | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 14 March 1928 | | | |
| 9. AGE (In years last birthday) 38 yrs. | | | | 10. BIRTHPLACE (County & State, or foreign country) Maryland | | | | 11. CITIZEN OF WHAT COUNTRY? USA | | | |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 13. KIND OF BUSINESS OR INDUSTRY - HOME | | | | 14. BIRTHPLACE (County & State, or foreign country) Maryland | | | |
| 15. FATHER'S NAME Charles Brown | | | | 16. MOTHER'S MAIDEN NAME Cora Miner | | | | 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 18. SOCIAL SECURITY NO. 212-24-6393 | | | | 19. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland | | | | 20. ADDRESS | | | |
| 21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & Pseudomonas Septicemia DUE TO (b) Leukemia - type undetermined DUE TO (c) type INTERVAL BETWEEN ONSET AND DEATH 12 Hours 65 Days | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 23a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 23b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 23d. (City or town) | | | | 23e. (County) | | | | 23f. (State) | | | |
| 24. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 October , 19 66 , to 6 November 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6 November 19 66 , and that death occurred at 6:10 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 25a. SIGNATURE Jerry L. Spivak | | | | 25b. OATE SIGNED 6 Nov. 1966 | | | | 25c. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 25d. PHYSICIAN'S NAME (Type) Jerry L. Spivak, MD. | | | | 25e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | | |
| 26a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 26b. DATE THEREOF 11/9/66 | | | | 26c. NAME OF CEMETERY OR CREMATORY Gettysburg Church | | | |
| 26d. LOCATION (City, town or county) Gettysburg, Md. | | | | 26e. (State) Md. | | | | 26f. REC'D BY REGISTRAR NOV 10 1966 | | | |
| 26g. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md. | | | | 26h. ADDRESS | | | | 26i. REGISTRAR'S SIGNATURE Charles Judge | | | |

15320

15318

The National Bureau of Health, Baltimore, Maryland
19 Days

Female, white
In March 1938

Residence: Maryland

Charles Brown
The National Bureau of Health, Baltimore, Maryland
19 Days

Female - two children

October 1938

Institution of Health, Baltimore, Maryland

1938